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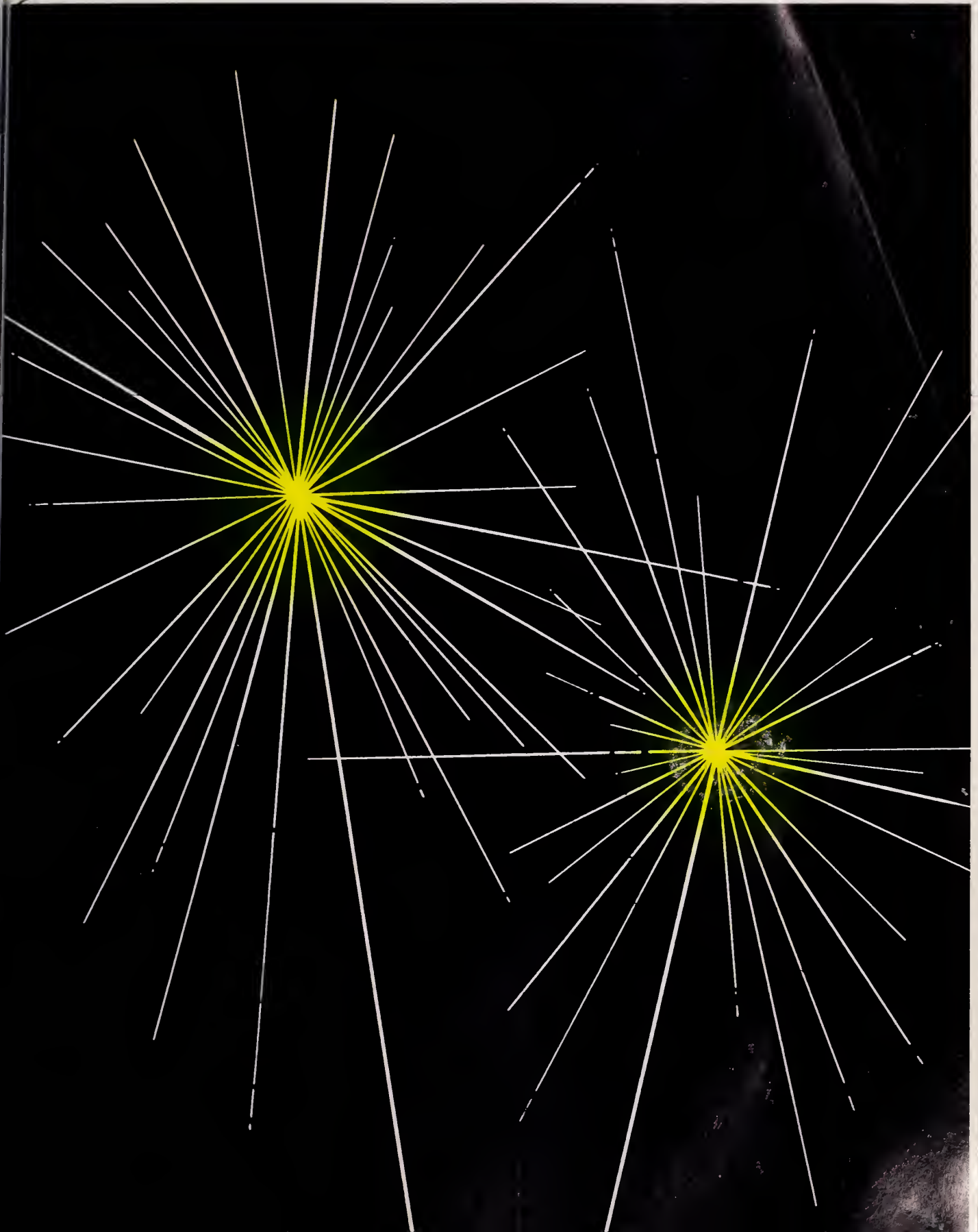


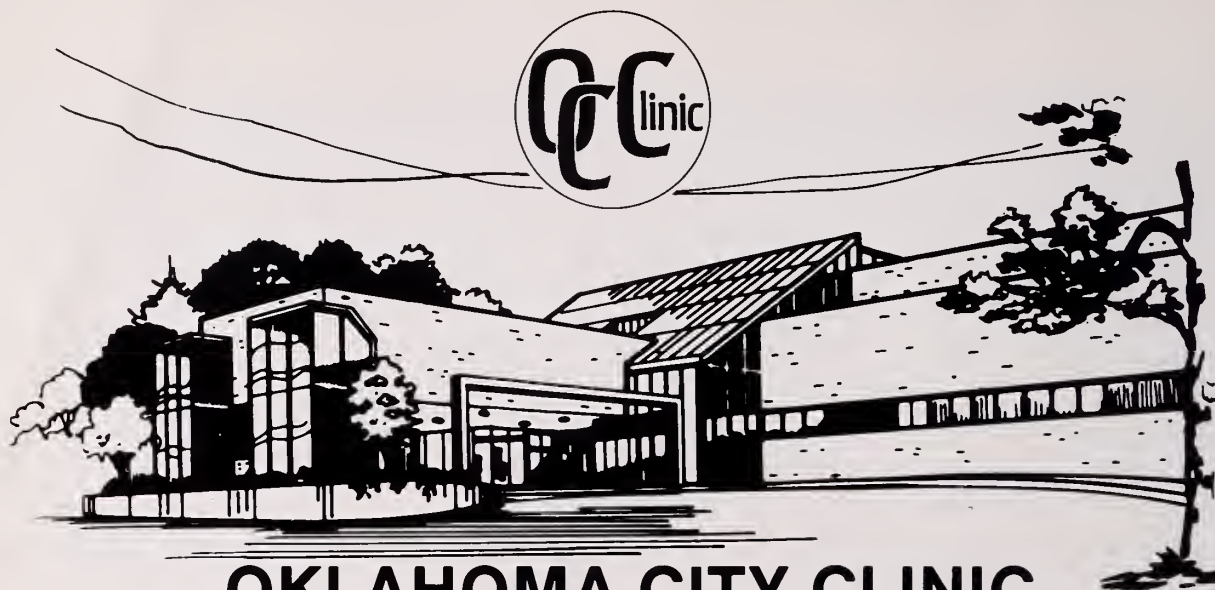




# JOURNAL *Oklahoma State Medical Association*

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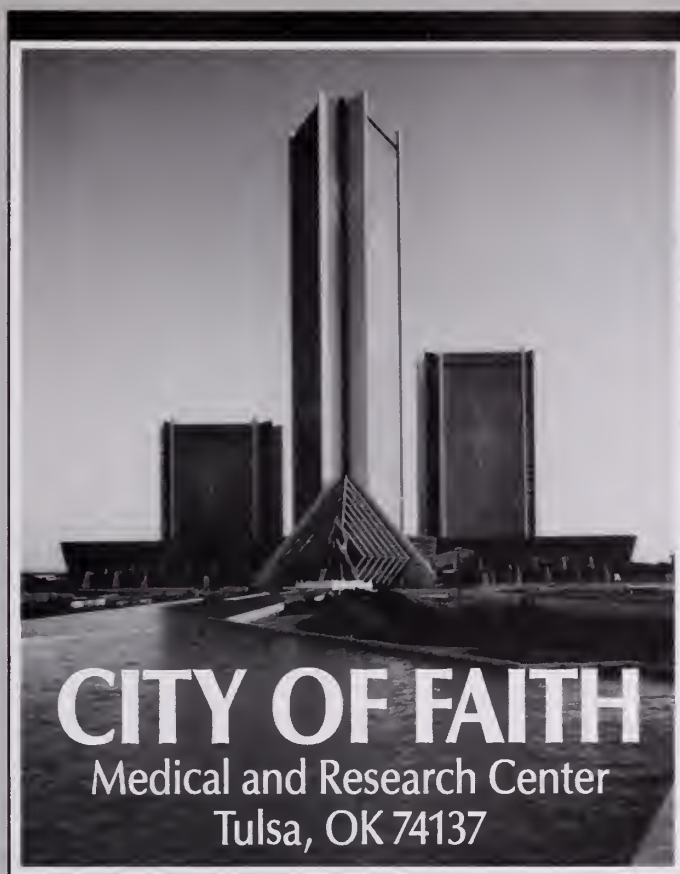
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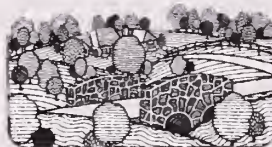


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# JOURNAL

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JULY 1985

VOL. 78, No. 7

#### EDITORIAL

Anyone Else Need Help? ..... 209  
MARK R. JOHNSON, MD

President's Page ..... 210  
ELVIN M. AMEN, MD

#### SCIENTIFIC

Continuous Subcutaneous Insulin Infusion (CSII) ... 211  
DON P. WILSON, MD; ROBERT K. ENDRES, MD

#### SPECIAL

Eliminating Pharmacists' Calls ..... 215  
ROBERT J. HOLT, RPH

#### COMMENTARY

Production and Utilization of Physicians in Oklahoma . 217  
CLAYTON RICH, MD

#### ANNUAL MEETING

Proceedings ..... 233  
Index to Proceedings ..... 15A

#### NEWS ..... 221

New officers and delegates elected at Annual Meeting . . .  
OSMA board names deputy executive director . . . House of  
Delegates kept busy in OKC . . . Physician Recovery Hotline  
now operating . . . AMA PRO monitoring needs you . . . Doc-  
tors and spouses take swings at Annual Meeting . . . PLICO  
board fills slots . . . Lambird wins AMA council post

#### DEPARTMENTS

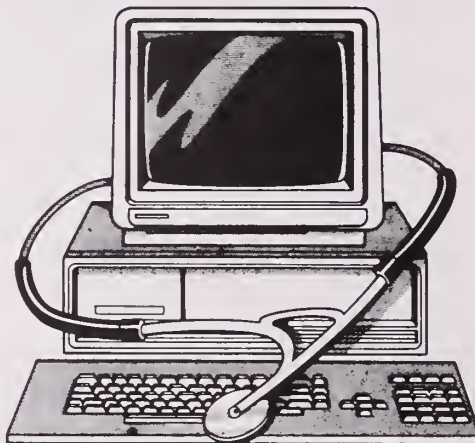
State Department		Miscellaneous Adv. . . .	232
of Health . . . . .	219	Index to	
Reaction Time . . . . .	228	Advertisers . . . . .	34A
In Memoriam . . . . .	228	Instructions	
Deaths . . . . .	228	for Authors . . . . .	34A
Book Reviews . . . . .	230	The Last Word . . . . .	36A

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**References:**

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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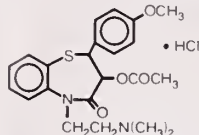


## PROFESSIONAL USE INFORMATION



### DESCRIPTION

**CARDIZEM®** (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)-one, 3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride, (+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

### CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

**Mechanisms of Action.** Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. **Angina Due to Coronary Artery Spasm:** CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. **Exertional Angina:** CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

**Hemodynamic and Electrophysiologic Effects.** Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

**Pharmacokinetics and Metabolism.** Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

### INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).

2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance. There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

### WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS AND ADVERSE REACTIONS.)

### PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

**Pediatric Use.** Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%),

headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia, and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

### OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levaterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral  $LD_{50}$ 's in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous  $LD_{50}$ 's in these species were 60 and 38 mg/kg, respectively. The oral  $LD_{50}$  in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

### DOSEAGE AND ADMINISTRATION

**Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm.** Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

#### Concomitant Use With Other Antianginal Agents:

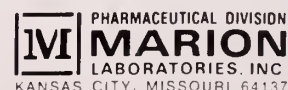
1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

### HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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# OKLAHOMA MEDICINE TODAY

## Reducing the stress in stress tests for coronary artery disease

### When exercise may be contraindicated

Many patients with chest pains cannot exercise adequately. Yet traditional stress tests require patients suspected of having coronary artery disease to perform treadmill or bicycle exercise involving vigorous leg motions.

Recognizing the inherent limitations of such testing, researchers at the Veterans Administration Medical Center and the University of Oklahoma Health Sciences Center joined in efforts to develop an alternative method which would be equally useful in evaluation while eliminating some of the disadvantages.<sup>1,2</sup>

### Investigating epinephrine infusion

Investigational studies were undertaken on the basis of the physiologic response to intravenous epinephrine infusion in patients with chest pains. Arterial blood pressure, systolic time intervals and ECG measurements were recorded before, during and after the infusion.

### Encouraging results to consider

While the patient sample was statistically small, the results were significant. The predictive value of a positive test for coronary disease was 100%, while the predictive value of a negative test for excluding coronary disease was 80%.<sup>2</sup>

Additionally, none of the patients suffered complications from the epinephrine infusion, nor were there signs of agitation or anxiety during the test period.

Further, epinephrine infusion has some specific advantages: since exercise is not required, patients with pulmonary disease, neurologic defects, peripheral vascular disease or other problems precluding exercise can be tested. The patient's cooperation is not required, the equipment requirements are minimal and inexpensive and, since the patient is lying quietly during the tests, other measurements may be taken concurrently, resulting in a saving of technician time.<sup>1,2</sup>

**References:** 1. Treadmill test alternative. *Diagnosis*, Jul 1983, p. 11.  
2. Schechter E, Wilson MF, Kang Y-S. *Am Heart J* 105:554-560, Apr 1983.

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\*Feighner JP, et al. *Psychopharmacology* 61:217-225, Mar 22, 1979

Please see summary of product information on following page.



## LIMBITROL® ® Tronquillizer-Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of moderate to severe depression associated with moderate to severe anxiety

**Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

**Warnings:** Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbital to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

**Precautions:** Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbital should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

**Adverse Reactions:** Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbital and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbital but requiring consideration because they have been reported with one or both components or closely related drugs:

**Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

**Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

**Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

**Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

**Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

**Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

**Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

**Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

**Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Overdosage:** Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

**Dosage:** Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbital DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbital Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

**How Supplied:** Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.



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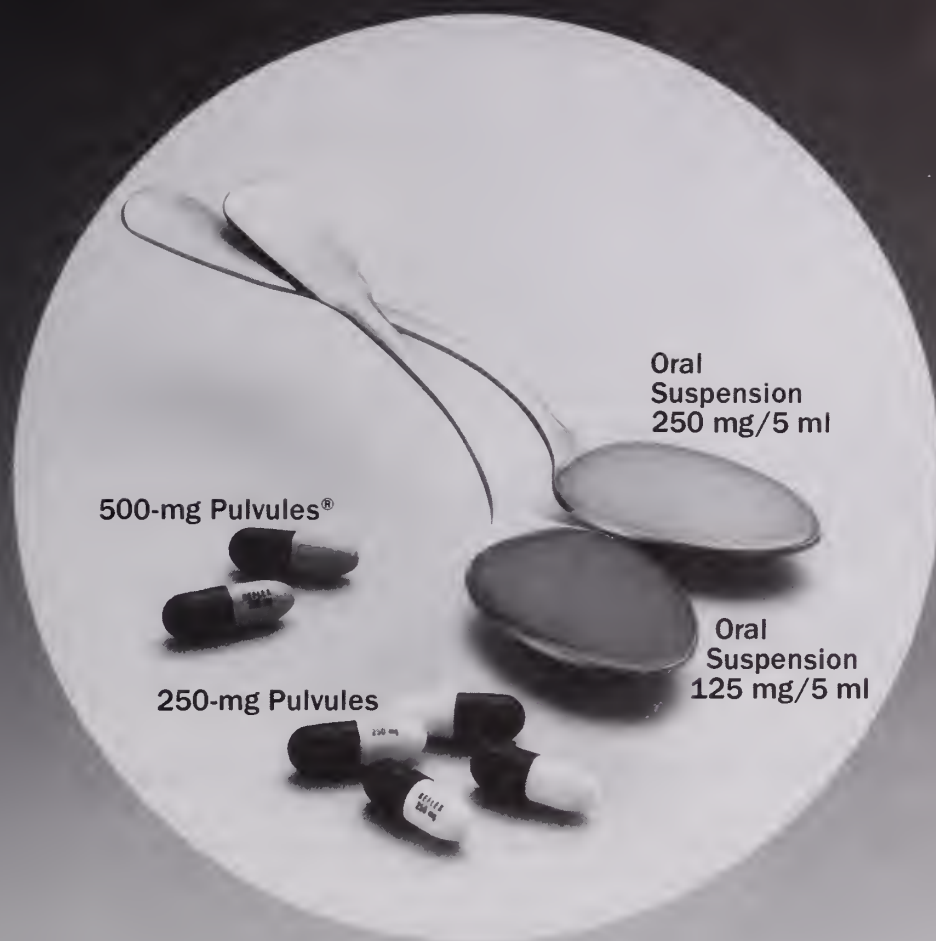
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## Anyone Else Need Help?

Medicare and Medicaid have been with us now for a few months more than twenty years. Looking back with a conscientious effort to maintain honest objectivity, I find it impossible to identify any certain benefits they have bestowed upon the people of this nation.

I can imagine the tone of outrage in the voices of those who will protest such a statement. They will declaim that the health care of the poor and the elderly has improved dramatically; that our diagnostic and surgical and therapeutic resources have expanded beyond the limits of our imagination; that millions of our citizens have been spared the humiliation of begging charity to provide their health care; that without the regulatory and monitoring safeguards contained in the Medicare and Medicaid laws, none but the very rich would now be able to afford the best available health care; that the increase in life expectancy over the past twenty years proves the effectiveness of Medicare and Medicaid.

Hardly persuasive, such allegations are pure, subjective nonsense which presumes that money is the root of all good, the facilitator of all charity, the object of all scientific endeavor, the basis of all compassionate, humanitarian concern, and the reason for all progress.

On the other hand Medicare and Medicaid have bestowed upon the people of this nation the tentacles of unmitigated socialism, economic ruin, and the abrogation of constitutional rights for a small but expanding category of citizens. Harsh assessments indeed, but more than subjective allegations, given the definitions of socialism, ruin, and constitutional rights.

Viewed as what they are *not* — Great Society plans for providing health care — Medicare and Medicaid have enjoyed the amorous affection of their beneficiaries and bureaucratic promoters; massive groups of people with vested interests and deafening political voices who do not hesitate to declare holy war against any infidel who dares to attack their adopted saviour.

Viewed as what they *are* — political programs designed first to subsidize then totally control one of this nation's largest and once its most politically independent industries — Medicare and Medicaid deserve the most meticulous and critical assessment possible by every American who cherishes justice, freedom, and independence. Look at what has happened in the past twenty years. Try to imagine what will happen in the next twenty years.

Perhaps it was pure coincidence, but Medicare and Medicaid were born a few months following a decision by the United States Supreme Court which said, in effect: "What the federal government subsidizes, the federal government will control."

Surely the poor and elderly of this nation need financial assistance in order to obtain the best possible legal services and all the natural gas and electricity they need. And the best possible food. And the finest clothes. Irrespective of their ability to buy their own. Already the money poured into the electorate and the bureaucracy in the name of Medicare and Medicaid has destroyed the vanguard.

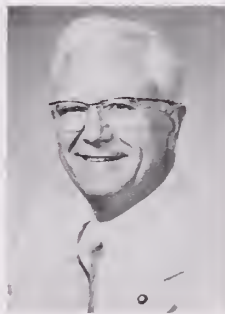
What's next?

—MRJ

We are now in the midst of vacation time. It is time to rest and restore our vitality to re-motivate ourselves to serve those in need of care.

We must examine ourselves carefully if we are to correct those behavior characteristics which have helped our opponents destroy the image of the physician.

A few of us have forgotten the high ideals we expressed when we entered medical school. Perhaps some of the polish of our ideals became tarnished by contact with unpleasantness during our training years, but a little self-evaluation will lead us to realize that contact with unpleasant things should not make us unpleasant. A single difficult patient should not make us difficult to all other patients who



follow. We must not allow a brush with a discourteous individual, either patient or nonpatient, to cause us to have a discourteous day. It is also possible, by tactful speech and pleasant face, to help someone else out of his disagreeable mood.

Public relations and the doctor's image are a challenge to all of us and to our families and employees. It is up to us to improve the image of the physician. We cannot expect the AMA or OSMA or others to accomplish a change; we must all work to restore the physician to his rightful place in the eyes of his fellow citizen.

YOU and I represent ALL PHYSICIANS in the eyes of the public. Let us set a worthwhile example.

Sincerely,

*Elwin M. Amen, M.D.*



# Continuous Subcutaneous Insulin Infusion (CSII)

DON P. WILSON, MD, and ROBERT K. ENDRES, MD

**Although more expensive than other methods of insulin delivery, insulin pumps are gaining popularity in the treatment of certain carefully selected patients.**

**T**he use of portable insulin infusion devices (insulin pumps) has become an increasingly popular method of treating insulin-dependent diabetes mellitus.

For the patient, this treatment method is more demanding and expensive than conventional methods of insulin delivery. Use of insulin pump therapy can correct many of the metabolic derangements characteristic of insulin deficiency. It is hoped that with prolonged improvements in glycemic control, the chronic complications known to occur in type I diabetes will be eliminated. Use of such devices has proved to be safe and beneficial in certain carefully selected, highly motivated patients.

## Intensified Insulin Delivery

Alarm over the significant number of patients who develop debilitating complications from their disease has sparked a renewed interest in tight control of diabetes. Such efforts have been referred to as "intensified" diabetes treatment regimens. For many patients, however, intensification begins with the basic rudiments of control. Significant improve-

ment occurs in such individuals when they acquire an adequate understanding of the pathophysiology of diabetes, have defined and realistic treatment goals, implement blood glucose monitoring, and improve dietary compliance.

Skyler et al<sup>1</sup> compared various insulin treatment methods including twice-daily mixtures of short- and intermediate-acting insulins, multiple preprandial injections of short-acting insulin combined with a long-acting insulin, and insulin pump therapy. They suggested that the insulin regimen alone was not the most important factor in improving glucose control, as long as the treatment attempted to mimic physiologic insulin secretion. They concluded that sustained glycemic control requires: (1) careful attention to *all* elements of management: diet, exercise, and insulin; (2) self-monitoring of blood glucose; (3) physiologic treatment targets; (4) algorithms for the adjustment of the treatment program; and (5) patient education and motivation.

## Principles

Current methods of insulin delivery using portable pumps involve continuous subcutaneous insulin infusion, or CSII. Insulin is given continuously over each 24-hour period as a "basal" infusion. Additional doses of insulin (or "bolus" infusions) are given approximately 30 minutes prior to meals and snacks. Initially patients are given approximately 40% of their estimated total daily insulin requirement as the

From the H. Allen Chapman Institute of Medical Genetics, Section of Endocrinology, Children's Medical Center, and the Southwestern Metabolism and Diabetes Center, Saint Francis Hospital, Tulsa, Oklahoma.

### Estimated Yearly Cost of Insulin Pump Therapy

#### I. Initial Investment

	Estimated Cost
A. Infusion pump	\$1,000.00 — 2,500.00
B. Glucose monitor	150.00 — 250.00
C. Blood letting device	15.00 — 25.00
<b>Total</b>	<b>\$1,165.00 — 2,775.00</b>

#### II. Maintenance Costs\*

	Estimated Use	Yearly Total	Estimated Cost
A. Pump Supplies			
1. Needles/tubing	1 q 3 days	122	\$ 250.00
2. Syringes	1 qd	365	180.00
3. Tape	1 q 3 days	122	75.00
B. SMBG			
1. Reagent strips	qid, 3-7X wk	624-1,456	\$375.00 — 874.00
2. Lancets	qid, 3-7X wk	624-1,456	32.00 — 75.00
<b>Total</b>			<b>\$912.00 — 1,454.00</b>

\*Does not include insulin

basal infusion. Previous authors have suggested adjusting the basal infusion rate dependent upon the fasting blood sugar level each morning. However, Raskin<sup>2</sup> cautions that the blood sugar level nadir (occurring at approximately 0200-0300 hours) should be determined in establishing or adjusting the basal rate, so that significant nocturnal hypoglycemia can be avoided.

The preprandial bolus doses of insulin are distributed as 20% of the daily requirement for breakfast, 15% for lunch, and 15% for supper. An additional 10% is available for snacks. The patient is given a set of guidelines for adjustments in insulin dose based on the results of blood glucose monitoring (generally obtained before meals and bedtime, with occasional testing 1½ to 2 hours postprandially). A schedule of "supplemental" insulin doses for unexplained hyperglycemia and illness is also provided.<sup>3</sup>

#### Indications for Pump Use

The American Diabetes Association has suggested the following indications for CSII<sup>4</sup>: (1) pregnancy; (2) failure to achieve acceptable control of blood glucose levels with an intensified conventional diabetic treatment program; (3) significant complications resulting from diabetes; and (4) other considerations, such as brittle diabetes and potential diabetic complications.

Most physicians agree that patient motivation is a key criterion for selecting patients who may be good candidates for pump use. It should be pointed out that when considering children for such therapy, it should be the *child* who exhibits enthusiasm, in addition to the parents and/or the physician! Without

the child's full consent and cooperation, such treatment is rarely successful and can be dangerous.

#### Mock Insulin Pump Program

During the past four years, we have used a "mock insulin pump" program to aid us in proper patient selection.<sup>5</sup> The child and the parents are informed of the general principles of CSII, the common complications, and the expected outcome of treatment. Estimated cost for equipment and supplies is discussed. The family's ability to reliably perform blood glucose monitoring is reviewed, with proper instruction given when indicated. The initial subcutaneous catheter is placed, under supervision, and proper catheter care and manipulation are taught. The child is instructed to wear the mock device continuously for two weeks, changing the indwelling catheter every three days. Insulin is given by conventional methods throughout the training period. Blood glucose monitoring is performed four times a day (before meals and bedtime) and the results recorded. The child is instructed to simulate premeal bolus injections. The system is capped for bathing and vigorous physical activity. We find this simple outpatient training program helpful for the following reasons:

1. Many individuals choose conventional intermittent subcutaneous therapy after the initial training period using the mock system. They find CSII cumbersome and/or they are unable to comply with the requirements inherent in this mode of therapy. Therefore, the training provides the child and the family a practical means of assessing the system which does not require a large monetary investment.

2. The training program helps to alleviate the

anxiety initially experienced by some children because of their unfamiliarity with or increased individual notoriety while using the insulin infusion pump. This anxiety may affect the initial attempts at blood glucose regulation when CSII is begun.

3. The program provides the physician a baseline assessment of the child's glucose control using conventional methods of insulin delivery.

## Psychosocial Implications

Having diabetes necessarily makes a child "different" from his or her peers. Particularly during adolescence, when self-image and peer acceptance are crucial, being "different" can be a source of great apprehension, frustration, and anger. Not uncommonly, adolescents with diabetes manifest denial. They rebel through dietary indiscretion or refusal to perform blood glucose monitoring, fearful of peer rejection. Use of CSII in such children is a constant reminder to them and their peers of the disease's presence. Such children, in general, are poor candidates for CSII. Careful patient selection is tremendously important in this population. With proper patient selection, no adverse effects on personality development or body image have been demonstrated.<sup>6</sup>

## Available Methods

Many types of infusion pumps are currently available. We find it useful to restrict our patients' choice of pumps. This simplifies training and improves the staff's familiarity with the operating systems, features, and common sources of malfunction characteristic of each model.

## Cost

Estimated initial and yearly maintenance costs for CSII are summarized in the table. Other than pump tubing and tape, the remainder of the maintenance costs are for blood glucose monitoring. Insulin and syringes are consumed in every form of treatment. Since most diabetologists feel blood glucose monitoring is key to any successful diabetes treatment program, perhaps a more valid comparison should consider only those items unique to pump therapy. Costs for blood glucose monitoring are based on a frequency of four blood tests per day, three to seven days a week. Since the optimal frequency of blood glucose monitoring is unknown, this estimate will vary with each patient.

## Complications

Although improved glycemic control with use of CSII can be achieved in most patients, such success is not without the potential for complications. Common problems include:

**Mechanical.** As with any equipment, mechanical failure is always a threat. Excluding operator errors, most pump malfunctions should be referred to the manufacturer for evaluation and repair. Replacement of broken parts such as syringe cradles, screws, or plastic components is a common necessity. We find most problems occur not with the pumps but with the tubing and the infusion site. One manufacturer recently recalled its catheter due to an improperly fitting Luer-lock. Undetected leakage of insulin through this defect resulted in hyperglycemia and, in several instances, diabetic ketoacidosis (DKA). The problem with crystallization of insulin in the catheter has been well recognized. This probably occurs because of changes in pH. Although occlusion of the catheter in such a manner should cause a back pressure alarm, we have found that in some systems insulin is forced out of the Luer-lock attachment between the syringe and the catheter or extension tub-

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## Patient motivation is a key criterion for selecting patients.

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ing without triggering the alarm. Because little or no insulin is administered to the patient, DKA results.

**Metabolic.** In any regimen attempting euglycemia, the occurrence of hypoglycemia is frequent. The constant delivery of insulin during CSII may make patients using this method more vulnerable to hypoglycemia by inhibiting hepatic glucose production. Alternatively, since only small amounts of short-acting insulin are present at any given time except following bolus doses, DKA may develop very rapidly if there is an interruption in insulin delivery, particularly if it goes undetected by the patient.

**Cutaneous.** A major source of complication is the cutaneous infusion site. Patients may exhibit allergies to the tape, the tubing, or the metal needle. With improper cleaning of the skin site or as a result of prolonged catheter use, infection resulting in cellulitis or abscess may result. The presence of inflammation may alter local insulin absorption. Lipodystrophy is infrequent, perhaps as a result of the mode of insulin delivery or the type of insulin used. However, the induction of nodule information can be an annoying and cosmetically undesirable problem. The explanation for these nodules is unclear. They may result from an inflammatory reaction induced by movement of the subcutaneous catheter or from modifications in the insulin.



**Death.** The Centers for Disease Control identified 11 deaths in 1981 occurring among an estimated 4000 users of insulin infusion devices in the United States.<sup>7</sup> No evidence of pump malfunction or failure was found. A panel reviewing these deaths concluded that while none of the deaths could be directly attributed to the infusion pumps, some deaths may have been due to intensive attempts at maintaining euglycemia. It was further noted that in several instances, patients delayed contacting a physician despite abnormal blood glucose test results. Mortality estimates among a compatible group using other means of intensified insulin delivery to achieve similar goals are not available.

## Conclusion

Although questions about the long-term benefits of portable insulin infusion systems remain unanswered, current use of such devices is safe and beneficial in certain carefully selected, highly motivated children. Under these circumstances, many of the metabolic derangements characteristic of diabetes can be reversed. The ability of sustained glycemic control to delay or prevent vascular complications, however, remains to be proved. No adverse influence on personality development or body image has been identified. As in any successful diabetes treatment program, the general principles of management — diet, exercise, emotional stability, as well as insulin therapy — remain variables that should

be well understood by patients and their families. Combined with proper education, guidance, and support, new modes of treatment offer individuals with diabetes more promising futures than ever before. □

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*Co-author Robert K. Endres, MD, is clinical professor of pediatrics at Tulsa Medical College and is board certified in pediatrics-diabetes. Dr Endres is a member of the American Academy of Pediatrics, American Diabetes Association, and Eastern Oklahoma Pediatric Society. He was graduated from the University of Oklahoma School of Medicine in 1948.*

## Coming in August . . .

Among the manuscripts being considered for publication in August are a paper on the epidemiology of nontuberculous mycobacteria in Oklahoma, an example of bilaterally enlarged adrenal glands as a clue to disseminated histoplasmosis, and a personal account of the events following the tragic Star Elementary School explosion in Midwest City.



## Eliminating Pharmacists' Calls

ROBERT J. HOLT, RPH

**Frequently criticized for illegible handwriting, physicians are much more likely to be called about incomplete prescriptions, a preventable nuisance.**

**O**f the many frustrations besetting the practicing physician, one of the more frequent (and seemingly inconsequential) is the encounter with a pharmacist who phones with a question about a prescription. Whether the reason for the call is verification, refill authorization, legibility, or some other difficulty, the result is usually a minor nuisance for all concerned. However, the irritation surrounding such calls can be forestalled if the basis of the more frequent questions is understood and avoided: incomplete data.

Refill requests constitute the majority of pharmacists' calls to physicians, and with good reason. For most pharmacies, refills represent about half of all prescriptions dispensed (47% nationwide in 1983<sup>1</sup>), and all of those refills must be authorized by the prescriber, not just his nurse or receptionist or the pharmacist acting on his or her own volition.<sup>2</sup> Problems arise for several reasons. If the original prescription is not marked at all, it clearly cannot be refilled without the physician's approval, even in the case of usually chronic medication. The pharmacist has no way of knowing whether the physician prescribed the drug for a trial period or simply forgot to mark the original. Additionally, pharmacists often receive prescription forms with two blocks in the corner, one for "no refill" and the other labeled "refill." If the physi-

cian merely checks "refill," the number and frequency of refills is still unclear. Thus the pharmacist can refill the order only once before calling the prescriber for authorization.

At the opposite extreme is the prescription marked "refill prn." Under FDA guidelines, a prn designation is not a valid authorization for refilling a prescription,<sup>3</sup> so the pharmacist should contact the prescriber after a reasonable time to make sure the medication is to be continued. Problems arise, however, in determining what constitutes a "reasonable time"; some pharmacists will call every six months or one year, but others never call. In one case, a patient brought a prescription container to a pharmacy for transfer of the prescription order, but the date on the label was eight years earlier. The original pharmacy had been refilling it without verification for all that time. When the new pharmacist advised the patient that he would have to contact the physician for authorization, he was informed that was impossible; the doctor had been dead for five years. Since most pharmacists do not want the responsibility for such a prescription, the simplest solution is the abandonment of the practice of writing "prn" as a refill designation. A specific number of authorized refills or a specified time length would be much clearer to the pharmacist and safer for the patient. Furthermore, when the pharmacist must call after those refills are dispensed, a specific number should be conveyed; a simple "OK" can only mean one time.

The other major reason for the pharmacist to con-

tact the prescriber is verification of the initial order. Aside from the obvious and largely insoluble problem of altered and forged prescriptions, the pharmacist must determine the accuracy and appropriateness of each prescription he fills.<sup>1</sup> Though much less frequent than calls for refills, such questions are often significantly more serious.

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for refilling  
a prescription.**

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The most common difficulty is information missing from the original order: no quantity, incomplete directions for use, or lack of a "narcotic license" number or prescription date. Should the patient present the prescription for dispensing at 8:00 PM on a Friday, it becomes more than a minor nuisance. The patient may be prevented from getting the medication when needed or from taking it correctly. A simple check of the written prescription can eliminate the problem.

Questions about the appropriateness of the order are even more important than missing information. When a pharmacist asks for verification of a dosage frequency or strength which seems out of the ordinary, he or she is not questioning the ability of the

prescriber; the pharmacist's duty is to protect the public. The prescription is a small part of the physician's encounter with any one patient, often overshadowed by examination, diagnosis, and other therapies; and errors do occur. The pharmacist, on the other hand, has the prescription as a major focus; he only wants enough information to determine if the dosage is correct for the patient and the prescription is for a legitimate medical use. These are his legal responsibilities.

So, the key to solving the problem is cooperation between the physician and pharmacist, each making every effort to communicate effectively. If the prescriber's intentions are clear on the original order, there will be fewer calls from the dispenser. Finally, when the pharmacist must call, both pharmacist and physician must realize that they have one common goal: the patient's health. □

#### References

1. *Drugs Topics*, February 6, 1984, p 12.
2. Federal Food, Drug, and Cosmetic Act, Section 503(b) (1).
3. Food and Drug Administration interpretation of the Durham-Humphrey Amendment to the Federal Food, Drug, and Cosmetic Act, Section 503(b) (1).
4. Code of Federal Regulations, Title 21, Section 1306.04

*Robert J. Holt, RPh, is adjunct assistant professor of pharmacy practice and acting director of continuing education at the University of Oklahoma College of Pharmacy. A 1979 graduate of the College of Pharmacy, he is a member of the American Pharmaceutical Association, American Association of Colleges of Pharmacy, American Society of Hospital Pharmacists, and Oklahoma Pharmaceutical Association.*

I would never use a long word, even, where a short one would answer the purpose.

I know there are professors in this country who "ligate" arteries.  
Other surgeons only tie them, and it stops the bleeding just as well.

— Oliver Wendell Holmes

# Production and Utilization of Physicians in Oklahoma

CLAYTON RICH, MD

**Dr Rich is Provost at the University of Oklahoma Health Sciences Center. The following is his response to the article "Estimated Physician Manpower Requirements for Oklahoma in 1990" by F. Daniel Duffy, MD; C. S. Lewis, Jr., MD; and Deborah A. Miller, MS, which appeared in the JOURNAL last month.**

In the June 1985 issue of the JOURNAL, Lewis and Duffy analyze the physician manpower needs of Oklahoma to project an undersupply of physicians now and in the foreseeable future. This forecast runs counter to a strong perception among physicians in Tulsa and Oklahoma City that a current oversupply is getting worse.

There were 141 physicians per 100,000 population in Oklahoma in 1984, whereas the target number arrived at by the Graduate Medical Education National Advisory Council (GMENAC) in 1981 was 191. Furthermore, given current rates of physician production, retirement, and migration, Lewis and Duffy project that there will be only 167 physicians per 100,000 population in 1990, still 13% below the GMENAC target figure.

The apparent discrepancy between this projection and the perception of oversupply most probably is because the GMENAC target figure is an estimation of the need for physicians under optimal conditions in which there would be no economic, geographic, or cultural barriers to medical care. However, the per-

ceived oversupply of physicians in Oklahoma and across the country is based on actual utilization rates, which very definitely are constrained by such barriers, and increasingly, by the impacts of competitive and corporate medicine.

The GMENAC study focused on optimal need rather than utilization because it was not considered feasible to project either the conditions of practice of the future or how those conditions would affect utilization. Nevertheless, the current policy issue concerning the number of physicians who should be trained needs to be dealt with in terms of utilization rather than optimal numbers.

Factors which have restricted access in the past, such as poverty, low educational level, and distance from medical services, probably will continue to be important, although their impacts may vary in the future. In addition, the new trends related to HMOs, competition, and corporate medicine can be expected to have quite complex and profound effects. Rural networking of urban-based HMOs may channel patients to urban hospitals. This and a continued shift of population to urban areas should increase access to specialty care. The development of large, vertically integrated health care corporations should improve efficiency, but may not reduce the need for specialists to any great degree. In fact, the pervasive public interest in high-quality medical care is the cause now of these corporations competing for name recognition and market share on the basis of high quality services, including the exact kind of costly high tech-

Clayton Rich, MD, Provost, University of Oklahoma Health Sciences Center, P.O. Box 26901, Oklahoma City, OK 73190.



nology for which the traditional medical care system has been criticized.

These and other considerations lead to what can only be expressed as an informed opinion; that the utilization of physicians in the future may very possibly be approximately 10% below the optimal figure derived from the GMENAC study, with lower utilization in predominantly rural states than in predominantly urban states, and with the percentage of all physicians utilized in primary care being approximately that derived in the GMENAC study. This would project a figure based upon assumed utilization of 172 physicians per 100,000 population, of whom 45% would be primary-care physicians.

It is interesting to note that, historically, there was a perceived severe shortage of physicians in this

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---

country until the mid-1970s, during a time when the number of physicians per 100,000 population was below 170, but that this perception has diminished since, when this number has been above 170.

The approach of Lewis and Duffy probably is the best available for examining future need and utilization. They have obtained very useful information relating future supply to optimal numbers by specialty and geographic district of Oklahoma. An informed opinion about the relationship between optimal num-

bers and future utilization has been given above. Finally, Lewis and Duffy's approach can be used to evaluate the possibility of an undersupply of physicians resulting from a reduction in medical school class size.

If one assumes that the current rates of physician production, migration, and retirement will remain constant, and a 20% population growth between 1990 and 2000, the projected number of physicians per 100,000 population would be 195 in the year 2000. That exceeds the figure given above as a reasonable assessment of probable future need.

A reduction of the entering MD and DO class size in 1985 would have a minimal effect before 1990 on the number of physicians in practice because medical school and residency training for MDs and DOs averages six years. A 15% reduction in 1985 would reduce the number of physicians in the year 2000 to 189 per 100,000 population.

If the class size were decreased and the population grew by 30% between 1990 and 2000 rather than 20%, the number of physicians in the year 2000 would be 174 per 100,000 population. Finally, if both of these changes occurred and, in addition, the current rate of migration of physicians into the state decreased by 50% in 1990 and thereafter, the number of physicians projected for the year 2000 would be 163 per 100,000 population.

Even given the high degree of uncertainty about projections of the number of physicians and the utilization of physicians' services in the future, it would appear from the analysis given above that an oversupply could be averted by a 15% reduction of class size in 1985. Unless there were rather substantial changes in the current trends of population growth and migration of physicians, the resulting supply of physicians should continue to meet the state's needs. □

Do not waste the hours of daylight in listening to that which you may read by night.

— Sir William Osler



## Influenza Surveillance System

Thanks to the cooperation of physicians, schools, and county health departments, the Oklahoma State Department of Health's Influenza Surveillance System functioned well again for the 1984-85 season.

Through the week ending January 13, 1985, there was an average weekly baseline of 216 cases of influenza-like illness. For the period January 20 through March 10, weekly reports exceeded twice the average baseline rate, peaking with 945 cases in the week ending February 10.

The Public Health Laboratory reported several positive influenza cultures this season. All were identified as Type A (H3N2), a strain similar to A Philipines. No other influenza viruses were isolated.

The percentage of total deaths attributable to pneumonia and influenza (P and I) is one marker of the severity of influenza during a particular season. In 1980-81, when influenza caused significant morbidity, the national P and I death rate peaked at 7.0%. This season, the peak was 7.2%, indicating that influenza was responsible for a substantial number of deaths.

The health department plans to continue influenza surveillance in order to continue to provide timely, relevant information to the medical community and the general public about the occurrence of influenza. □

DISEASE	April 1985	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	1	5	6	7
CAMPYLOBACTER INFECTIONS	21	63	45	—
ENCEPHALITIS, INFECTIOUS	0	9	5	8
GIARDIA INFECTIONS	12	59	58	—
GONORRHEA (Use ODH Form 228)	914	3998	3866	4981
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	18	73	74	—
HEPATITIS A	31	168	150	167
HEPATITIS B	14	56	53	77
HEPATITIS, NON-A NON-B	3	19	13	—
HEPATITIS UNSPECIFIED	7	28	38	74
MEASLES (RUBEOLA)	0	0	4	62
MENINGITIS, ASEPTIC	2	9	15	19
MENINGITIS, BACTERIAL				
(non-meningococcal,				
non H. Influenzae)	5	21	20	24
MENINGOCOCCAL INFECTIONS	4	13	14	15
PERTUSSIS	21	34	117	117
RABIES (Animal)	12	38	44	74
ROCKY MOUNTAIN				
SPOTTED FEVER	2	3	1	10
RUBELLA	0	0	0	0
SALMONELLA INFECTIONS	19	86	90	89
SHIGELLA INFECTIONS	7	41	34	90
SYPHILIS (Use ODH Form 228)	18	67	67	68
TETANUS	0	0	0	0
TUBERCULOSIS	17	75	67	102
TULAREMIA	0	1	1	3
TYPHOID FEVER	0	0	1	1

Diseases of Low Frequency	Total to Date This Year	
ACQUIRED IMMUNE DEFICIENCY SYNDROME	0	
BRUCELLOSIS	3	
LEGIONNAIRES DISEASE	3	
MALARIA	0	
REYE SYNDROME	2	
TOXIC SHOCK SYNDROME	3	
RABIES		
CARTER	Skunk	1
CUSTER	Skunk	1
KAY	Skunk	2
KIOWA	Cow	1
MAYES	Skunk	1
NOWATA	Skunk	1
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## Meeting hosts election of OSMA officers and AMA delegates

The election of officers and delegates was a top-priority item at the Oklahoma State Medical Association's 79th Annual Meeting in early May.

Assisting new OSMA President Elvin M. Amen, MD, Bartlesville, in his recently assumed responsibilities will be Norman L. Dunitz, MD, Tulsa, OSMA president-elect. Dr Dunitz, an orthopedic surgeon, is a 1927 graduate of the University of Iowa College of Medicine, Iowa City. He is a member of the American Board of Orthopaedic Surgery and a Fellow of both the American Academy of Orthopaedic Surgery and the American College of Surgeons. Dr Dunitz is the immediate past president of the Tulsa County Medical Society.

Completing the slate of officers are M. Joe Crosthwait, MD, Midwest City, vice-president, and Raymond L. Cornelison, Jr., MD, Midwest City, secretary-treasurer. Michael J. Haugh, MD, Tulsa, is chairman of the Board of Trustees.



John Coury, MD, (right) chairman of the AMA Board of Trustees, presents to OSMA President Elvin M. Amen, MD, the AMA's 1984 Membership Award. The award is given to those state associations whose AMA membership in a given year exceeds the prior year's total. The presentation was made at the 1985 AMA National Leadership Conference.

Uncontested in their re-election to two-year terms as AMA delegates were Ed L. Calhoon, MD, Beaver; James B. Eskridge III, MD, Oklahoma City; Victor L. Robards, Jr., MD, Tulsa; and Orange M. Welborn, MD, Ada.

Also returned to office in uncontested elections were AMA alternate delegates William O. Coleman, MD, Oklahoma City; Michael J. Haugh, MD; George H. Kamp, MD, Tulsa; Arnold G. Nelson, MD, Midwest City; and James B. Pitts, Jr., MD, Oklahoma City.

In the only contested race for AMA alternate delegate, John R. Alexander, MD, Tulsa, was selected to fill the position formerly held by the late William M. Leebron, MD.

Other members of the Oklahoma delegation to the AMA are delegates M. Joe Crosthwait, MD, chairman; Floyd F. Miller, MD, Tulsa; and Perry A. Lambird, MD, Oklahoma City; and alternate delegate John A. McIntyre, MD, Enid. □

## OSMA Board of Trustees names new deputy executive director

OSMA Associate Director Rick Ernest was named Deputy Executive Director by the OSMA Board of Trustees in May.

The promotion was announced during the board's Wednesday night dinner at the OSMA's Annual Meeting in Oklahoma City.

Formerly Director of Personnel at Norman Municipal Hospital, Ernest joined the OSMA in 1977. In addition to his new duties he will continue as staff liaison to the OSMA's councils on Medical Education, Medical Services, and Hospital Medical Staffs.

Ernest holds membership in several professional organizations including the American Association of Medical Society Executives, the American Hospital Association, and the American Society of Association Executives. He is a graduate of the University of Oklahoma. □

## Three days of business in OKC keep House of Delegates busy

The OSMA House of Delegates handled a large volume of resolutions and reports at its Annual Meeting in May, and the complete text of those proceedings is included elsewhere in this issue.

However, in summary, actions approved by the House included the following:

- \*Recommendation that PLICO modify its health policy to include broader coverage for outpatient psychiatric services.

- \*Approval of the creation of three new delegate sections in the House of Delegates — a Hospital Medical Staff Section, a Resident Physician Section, and a Medical Student Section.

- \*Recommendation that the Oklahoma Medical

Political Action Committee (OMPAC) intensify its membership efforts and that OSMA members be encouraged to contribute a minimum of \$50 annually to support OMPAC's activities.

- \*Recommendation that the OSMA implore the Board of Medical Examiners to pursue earlier disciplinary and rehabilitative efforts in dealing with impaired physicians.

- \*Elimination of appeals of PLICO underwriting decisions to the OSMA Board of Trustees. Decisions of the PLICO Board of Directors will now be final.

- \*Encouragement of closer affiliation between the psychiatric training programs of the OU College of Medicine and the Oklahoma Department of Mental Health.

- \*Approval of reactivation of the OSMA Fee Review Committee.

- \*Recommendation that the OSMA and AMA urge Congress to end federal subsidies to tobacco growers.

- \*Recommendation that the OSMA petition the Oklahoma State Legislature and US Congress to impose a user fee on tobacco products, said fee to be used for the funding of treatment for smoke-induced illnesses and related research.

- \*Recommendation that AMA legal and scientific staffs study the implications of prospective evaluation of radial keratotomy and issue a report at the AMA Interim '85 Meeting.

- \*Recommendation that the OSMA take a public stand against the requirement of hospital pre-admission certification by government, industry, and private health insurance carriers. □



A.H. Robins representative Gary Jones (left) presents the 1985 A.H. Robins Award for Community Service to John A. Blaschke, MD, Oklahoma City, in recognition of his humanitarianism and countless hours of volunteer work in the community. The award was presented at the Opening Session of the OSMA House of Delegates in May.



Mark H. Mellow, MD, (left) and Gretchen A. McCoy, MD, of Oklahoma City receive the Charlotte S. Leebron Memorial Trust Award from Mark R. Johnson, MD, editor-in-chief of the JOURNAL. Presented at the OSMA Annual Meeting, the award goes to the authors of the best scientific article published in the JOURNAL each year.

## Drug dependency problem? Call OSMA Physician Recovery Hotline

The OSMA Physician Recovery Hotline, (405) 691-7318, is now in operation.

The telephone hotline has been established to provide aid and information to physicians with alcohol or chemical dependency problems or who are concerned about a colleague with a possible problem.

The telephone will be answered by a member of the OSMA's Physician Recovery Committee, making all inquiries physician to physician. Strict confidentiality is assured.

Initially the hotline will be staffed by physicians during regular weekday business hours.

The OSMA Physician Recovery Committee serves as an advocate for physicians with dependency problems. If you or one of your colleagues needs their help, call today. □

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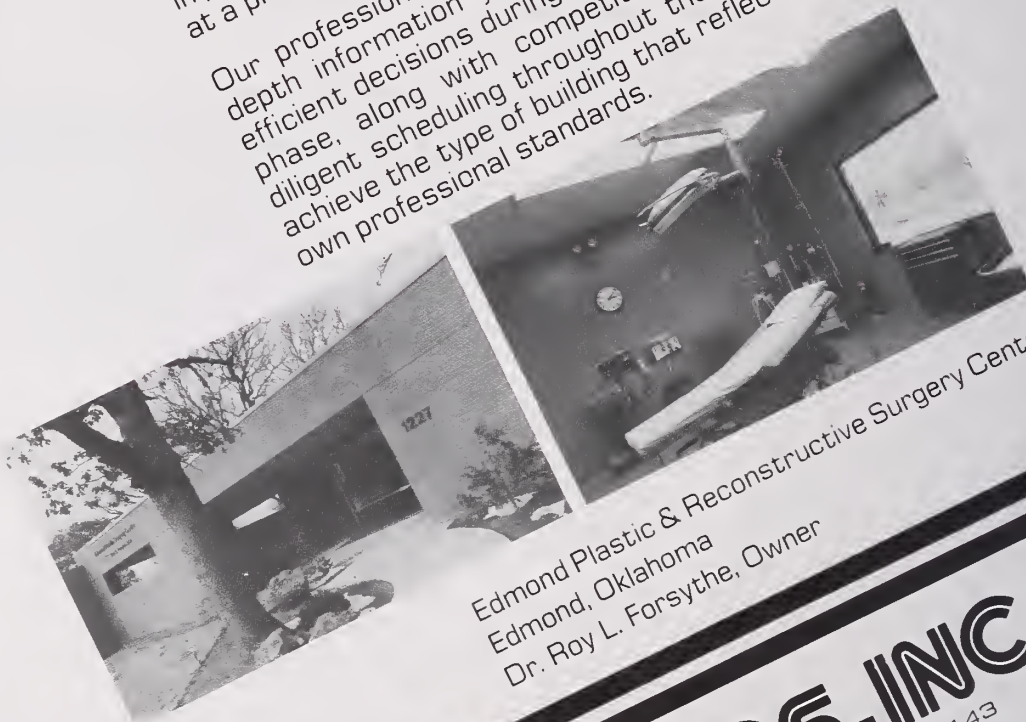
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# AMA seeks help of MDs, hospitals in PRO monitoring project

The American Medical Association has announced a new program to evaluate physicians' and hospitals' experiences with the Peer Review Organizations (PROs) set up to monitor the health care delivered to Medicare beneficiaries. Under the PRO program, both utilization and quality issues will be looked at by state-level PROs under contract to the federal government. A percentage of all Medicare discharges will be reviewed with respect to a set of quality and utilization objectives contractually agreed to by each PRO with the Health Care Financing Administration (HCFA).

The AMA is interested in learning of individual physicians' and hospitals' experiences, both positive and negative, which they feel are attributable to the new peer review system. While the AMA is interested in all relevant experiences, areas of particular interest include: changes in length of stay, admission and discharge policies, preadmission certification procedures, utilization and quality review results, administrative relations between hospitals and physicians and the PROs, any demonstrable impact

that PRO review may have on the cost or quality of care, and the results of any PRO efforts to review patients other than Medicare beneficiaries.

Physicians or hospital medical staffs who would like to share this information with the AMA are encouraged to describe their experience(s) in a brief letter and direct it to: AMA PRO Monitoring Project, Department of Health Care Financing & Organization, American Medical Association, Post Office Box 10947, Chicago, Illinois 60610.

All sources of information provided will be kept confidential. The data will be carefully analyzed and the results used by the AMA as the association pursues further involvement with PROs and as it develops new ways to assist physicians and medical staffs in dealing with this program. □

## PLICO Board of Directors adds new members at May meeting

The Physicians Liability Insurance Company (PLICO) held its annual meeting in Oklahoma City in early May, in conjunction with the OSMA's Annual Meeting.

To be filled at the meeting were five positions on the PLICO Board of Directors.

Incumbents James B. Eskridge III, MD, Oklahoma City; Eugene G. Feild, MD, Tulsa; and David M. Selby, MD, Enid, were re-elected to the board. New members elected at the meeting were William O. Coleman, MD, Oklahoma City, and Edwin E. Rice, MD, also of Oklahoma City.

Other members of the PLICO Board of Directors are C. Alton Brown, MD, Oklahoma City, president; Kenneth W. Whittington, MD, Bethany; C.S. Lewis, Jr., MD, Tulsa; John A. McIntyre, MD, Enid; Edward K. Norfleet, MD, Vinita; Ed L. Calhoon, MD, Beaver; Billy R. Goetzinger, MD, Oklahoma City; Floyd F. Miller, MD, Tulsa; Ray V. McIntyre, MD, Kingfisher; Billy Dale Dotter, MD, Okeene; John R. Alexander, MD, Tulsa; and David Bickham, OSMA executive director. □

## Doctors and spouses take swings at Annual Meeting sports events

Pleasure was mixed with business at the OSMA's Annual Meeting in Oklahoma City as physicians and their spouses took to the golf links and tennis courts to determine the winners of the annual sports get-togethers.

The golf competition began at 1:30 PM on Thursday, May 2, at the Kickingbird Golf Course in Edmond. Don Cooper, MD, Stillwater, had the Low Net. Finishing with the Low Gross was Lawrence Silvey, MD, Bethany; Leon Combs, MD, Shawnee, was second. Dr Silvey also shot Closest to the Pin. Dan Rains, MD, Shawnee, won the Longest Drive competition.

In the meantime, Woodlake Racquet Club in Oklahoma City was hosting the tennis matches. The men's singles winner was Chris Martin, MD, Edmond. In the men's seniors division David Snyder, MD, Oklahoma City, finished in first place and Farris W. Coggins, MD, also of Oklahoma City, finished second.

In the men's doubles, Snyder teamed with Lee Ison, MD, Midwest City, to take first. The team of Coggins and Martin won second place.

Annabel Pinzon, Oklahoma City, won first place in the ladies' tennis rounds, with Mary Frances Coggins, Oklahoma City, and Ruthanne Cagle, Oklahoma City, finishing second and third, respectively. □

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For being a friend of medicine and of the OSMA, Edward K. Norfleet, MD, (right) Vinita, receives a special award from Floyd Miller, MD, OSMA past president and AMA delegate. Dr Miller presented the award of appreciation on behalf of the entire OSMA House of Delegates at their Annual Meeting in Oklahoma City.

## Dr Lambird elected to AMA Council on Medical Service

Perry A. Lambird, MD, Oklahoma City, was elected to a three-year term on the American Medical Association Council on Medical Service during the AMA House of Delegates meeting in Chicago in June.

The council deals with socioeconomic issues in health care such as national health insurance and health care financing, planning, and organization. The council is composed of ten physicians, one resident physician, and one medical student.

Dr Lambird, with the full and tireless support of the Oklahoma delegation, won a hotly contested race among eight physicians, including three incumbents. Four positions on the council were available.

Dr Lambird becomes the first Oklahoma physician in over fifteen years to be elected to a national AMA post. ☐



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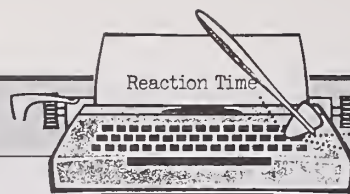
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## Doctor calls for reevaluation of lipid in TPN

The gastroenterology group at Toronto under the leadership of K. N. Jeejeebhoy has published a controlled study of total parenteral nutrition (TPN) in which all the nonprotein calories were given as glucose or two different regimens including lipid. One half of the patients received 25% of the nonprotein calories as lipid and the other half received 75%; in both there was crossover with 100% glucose. Somewhat surprisingly there was no difference in the data generated on resting energy expenditure, protein synthesis, or protein breakdown. Even the data on CO<sub>2</sub> production were only marginally different, and

as expected, the levels were higher in the patients receiving 100% dextrose.

This study, together with a consideration of costs, raises pointedly the question of why we give so much lipid.<sup>1</sup> It seems that most surgeons and most gastroenterologists prescribe supplemental lipid such as Liposyn and Intralipid on a daily basis from the start of hospital TPN.

There are factors which militate against using lipid; they include several side effects, but the chief factor is cost. In a recent assessment based on in-hospital pharmacy bills, approximately 45% of the cost of TPN incurred on days in which lipid is given is accounted for by the lipid component of TPN.<sup>2</sup> This is a major cost factor that ought to be buying us something in the care of the patients.

Clinical deficiency of lipid in fact has been rare, although it seems to have occurred most notably in the papers of Riella and Scribner and a paper by Holman et al, in which a child on TPN for five months developed nervous system symptoms which responded to replacement of linolenic acid<sup>3,4</sup>; it is noteworthy that this child had been on regular lipid supplementation of her TPN. Clinical deficiency seems not to have been reported before 47 days of fat-free TPN.

The biochemical hallmark of lipid deficiency de-

### IN MEMORIAM

#### 1984

<i>Grace C. Hassler, MD</i>	<i>July 14</i>
<i>Carryl W. Wiggins, MD</i>	<i>July 17</i>
<i>Solomon Papper, MD</i>	<i>August 19</i>
<i>Kirk T. Mosley, Jr, MD</i>	<i>August 26</i>
<i>Ingvald John Haugen, MD</i>	<i>September 1</i>
<i>Hugh H. Monroe, MD</i>	<i>September 9</i>
<i>Martin H. Bartlett, MD</i>	<i>September 10</i>
<i>Seth D. Revere, MD</i>	<i>October 6</i>
<i>Oliver H. Patterson, MD</i>	<i>October 13</i>
<i>Emmett H. Lindley, MD</i>	<i>November 8</i>
<i>Clark H. Hall, MD</i>	<i>December 5</i>
<i>Henry G. Bennett, Jr, MD</i>	<i>December 18</i>
<i>Adoniram V. Bowen, MD</i>	<i>December 29</i>

#### 1985

<i>Owen L. Hill, MD</i>	<i>January 15</i>
<i>Earl M. Lusk, MD</i>	<i>January 30</i>
<i>Larry L. Lowery, MD</i>	<i>February 12</i>
<i>Harry Wilkins, MD</i>	<i>February 14</i>
<i>William H. Buchan, MD</i>	<i>February 15</i>
<i>Austin H. Bell, MD</i>	<i>February 23</i>
<i>Glen W. McDonald, MD</i>	<i>February 25</i>
<i>E. C. Lindley, MD</i>	<i>March 1</i>
<i>Charles W. Freeman, MD</i>	<i>March 5</i>
<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Roy W. Donaghe, MD</i>	<i>May 1</i>

### DEATHS

#### Roy W. Donaghe, MD 1908 - 1985

OSMA Life Member Roy W. Donaghe, MD, died May 1 in Norman after a lengthy illness. Dr Donaghe, a pediatrician, was graduated from the University of Oklahoma School of Medicine in 1947. He served his internship in Seattle, Wash, and at Crippled Children's Hospital in Oklahoma City before his active service in the US Army in Albuquerque and Lawton. A captain when he left the army, he established his medical practice in Norman in 1954. Dr Donaghe retired in 1977.



scribed by Holman in 1960 is an increased ratio of trienic to tetraenic lipids in the plasma. Unfortunately this test is not readily available. No more than 3% of patients receiving TPN clinically generate an abnormal ratio within the first week and only a minority do so in the second week. It would seem that most patients previously reasonably well nourished could wait until at least a week of TPN had been given to receive supplemental lipid.

One concern promoting the use of lipid more or less routinely in TPN was that many severely traumatized and septic patients were significantly "hypercatabolic." Better metabolic measurements have indicated that this phenomenon is uncommon to rare. Perhaps a better indication for supplemental lipid is insulin resistance because this correlates with continued persistent fat breakdown unless it is reversed with lipid supplementation. Thus, our use of lipid should probably be more selective.

*William H. Hall, MD*  
Oklahoma City



J. Raymond Hinshaw, MD, chief of surgery at Rochester, NY, General Hospital and a graduate of the University of Oklahoma College of Medicine, discusses the use of the carbon dioxide laser in solving both simple and complex surgical problems. His presentation was part of the OSMA's Scientific Program at this year's Annual Meeting in Oklahoma City.

1. Baker JP, Detsky AS, Stewart S, Whitwell J, Marliss EB, Jeejeebhoy KN: Randomized trial of total parenteral nutrition in critically ill patients: Metabolic effects of varying glucose-lipid ratios as the energy source. *Gastroenterology* 1984; 87:53-59.
2. Hall WH: Unpublished observations.
3. Riella MC, Provia JW, Wells M, Scribner BH: Essential fatty acid deficiency in human adults during total parenteral nutrition. *Ann Int Med* 1975; 83:786-789.
4. Holman RT, Johnson SB, Hatch TF: A case of human linolenic acid deficiency involving neurological abnormalities. *Am J Clin Nutrition* 1982; 35:617-623.

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## BOOK REVIEWS

**Pediatric Cardiology.** Volume 4. Edited by M.J. Godman. London and New York: Churchill Livingstone, 1981. Pp 788, illustrated, \$79.00.

This is not a textbook of pediatric cardiology. It is a compilation of some eighty-seven presentations delivered at the First World Congress of Pediatric Cardiology held in London in 1980. The presentations have been organized into categories in a fashion that results in smooth transition and a readable, coordinated volume. The subjects range from etiology and pathogenesis through unusual problems in congenital heart disease. There are several chapters in the section dealing with the pulmonary circulation. Attention is given to recent advances in our knowledge of myocardial dysfunction, the diagnosis and naming of congenital heart disease, new methods of investigation, the role of computers in pediatric cardiology, advances in pediatric cardiac surgery, and the management of the child after operation. Two particularly interesting chapters deal with geographic heart disease and discussion of the child destined to have heart disease in adulthood and the potential for prevention.

The articles represent the views of many experts in the field. They are generally informative and often thought-provoking.

This is a useful volume for all specialists treating the child with heart disease — the pediatrician, the pediatric cardiologist, the radiologist, and the surgeon, as well as their co-workers.

Harris D. Riley, Jr., MD  
Oklahoma City

**Surgical Infectious Diseases.** Edited by Richard L. Simmons and Richard J. Howard. New York: Appleton-Century-Crofts, 1982. Pp 1,172, illustrated, \$135.00.

In the preface the editors state, "In the past surgeons made some of the most important contributions to the development of early antiseptic techniques and the environmental control of infection." They point out that subsequent progress in the understanding of pathogenesis and treatment of infections has been made primarily by infectious disease specialists. For these reasons the editors believe that there is a compelling need for a comprehensive textbook of surgical infections and point out that this is the first such effort since the publication in 1949 of *Clinical Aspects and Treatment of Surgical Infections* by Meleney.

This enormous tome covers activities and progress made during the past thirty years, beginning with an interesting chapter entitled "Surgical Infection

and History." The first half of the book encompasses a detailed discussion of the basic microbiologic and pathophysiologic aspects of surgical infections along with the technical aspects of the prevention of wound infections. The second half deals with specific clinical problems.

The book is divided into eight sections — history, surgical microbiology, host defenses, systemic responses to infection, antimicrobial therapy, wound infections, regional surgical infections, and special problems in surgical infections which encompass tetanus, burns, and infection in the immunocompromised host. Virtually all of the contributors are surgeons or connected with departments of surgery. As in most multiauthored books, there is some unevenness of quality. The lengthy chapter on host defense mechanisms translates well current research in this most important field. The emphasis seems uneven in certain areas, with considerably more space delegated to infections of the skin and soft tissues than to treatment of burns and certain other areas.

In some chapters there is a deviation from the theme of surgical infections; the role and use of antimicrobial agents are duplicated in several different chapters.

This work seems likely to become a standard reference on surgical infections and should be in the library of every major hospital.

Harris D. Riley, Jr., MD  
Oklahoma City

**The Maya Book of the Dead: The Ceramic Codex. The Corpus of Codex Style Ceramics of the Late Classic Period.** By Francis Robicsek and Donald M. Hales. Charlottesville, Virginia: Published by the University of Virginia Art Museum; distributed by the University of Oklahoma Press, Norman, Oklahoma, 1981. Pp 257, illustrated, price \$48.50.

This is a very attractive book. As Michael D. Coe of Yale University states in his foreword, "With this book, the study of Classic Maya pictorial ceramics has come of age." Crocker and Coe first designated a well-defined group of vessels as "codex style" because they resembled the style of the codices of the ancient Maya and because they believed that the artists who created these Maya masterpieces were the same ones who were accustomed to bark paper books of the ancient Maya. From this assumption Robicsek has championed the theory that the vases not only

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## Book Reviews (continued)

look like but, placed in proper sequence, are the codices, a theory which has profound meaning in Classic Maya research. This book describes the extensive studies and travels of Robicsek and Hales to Maya sites and to institutional and private ceramic collections. It is said to be the most complete study of the particular Maya ceramic style, covering all known examples. It is replete with excellent illustrations and is handsomely assembled and bound.

This is indeed a scholarly, carefully researched book that has important anthropological implications. It will be welcomed by all interested in Mayan culture.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Dermatology for the House Officer.** By Peter J. Lynch. Baltimore and London: Williams and Wilkins, 1982. Pp 277, illustrated. Price \$9.95.

This small book, another in the series "For the House Officer," is written for medical students and house officers involved with the care of patients. As pointed out in the preface, it is designed to be carried

to the clinical setting where it can be quickly used to establish a list of differential diagnoses, to confirm a suspected diagnosis, or to construct a therapeutic plan. "In short, it is a practical book for the self-learner."

This practical clinical manual is selective rather than encyclopedic. It covers sixty-five of the most frequent dermatologic conditions encountered by the physician. It utilizes the problem-oriented approach to diagnosis. The book is organized so that all of the diseases that look alike are grouped together, and it makes frequent use of diagnostic algorithms. It is arranged in three major sections: basic principles, problem-oriented diagnosis, and common problems in differential diagnosis. It contains five appendices which are helpful.

This is a useful "working" manual.

*Harris D. Riley, Jr., MD  
Oklahoma City*

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Proceedings of the

Oklahoma City

May 2-4

*79th*  
**Annual  
Meeting**

**Oklahoma State Medical Association**



## REPORT OF THE PRESIDENT to the OSMA House of Delegates

Mr Speaker, members of the House of Delegates, honored guests;

Seems like only yesterday . . .

Recalling the 355 days since the close of the 1984 Annual Meeting of OSMA, it *does* seem like only yesterday, though many things have occurred, many places have been visited, many problems faced and a few solved!

Four tightly filled handbooks (one for each quarter!) of Association correspondence in my bookshelves — certainly not all mine! — attest to the multiplicity of “issues” and happenings which have been confronted during these almost twelve months. Here are some examples.

*Item: Letter to Carolyn Davis, PhD, July 23, 1984.*

“On behalf of over 4,000 members of the Oklahoma State Medical Association, we offer the following comments:

“Most physicians realize that accuracy and honesty are basic requirements when filing claims on behalf of patients with any insurer . . . attestation required by Medicare implies that physicians may willingly and flagrantly violate federal law . . . like title children, must be reminded that penalties exist.

“The statement is not required by law . . . it antagonizes physicians unnecessarily. We urge that the statement be deleted entirely.”

As you know, the attestation statement was modified later, only slightly, now required only once per year.

*Item: Letter to Orange M. Welborn, MD, July 11, 1984.*

“This letter will serve as official confirmation of your appointment in Chicago, June 19, 1984 . . . immediately to . . . Delegate to AMA, Position VI.”

That letter, or similar, was duplicated for the remaining other Delegate and four Alternate Delegates who were appointed — and which the OSMA House will now have an opportunity to *elect*, since all have declared as candidates. Not only did the AMA House award two added Delegates and Alternates to unified states, last December the AMA House adopted a proposal to decrease AMA dues for members in unified states by ten percent per year, as long as the state association remains unified . . . also effective immediately.



*Item: “Dear Congressman Synar,” June 13, 1984.*

“I am pleased to learn, though somewhat surprised, that you ‘understand your (physician) opposition’ to Medicare Mandatory Assignment . . . deemed ‘necessary to compliment a freeze on reimbursement rates for physicians services to hospital in-patients.’ Certainly, the forces pressing Medicare to a financial crisis are real but the measures being sought by government to correct the fiscal status are largely biased against our honorable profession.”

This tightly typed page-and-a-half letter to Honorable Mike Synar brings back memories of my first meeting with Mike later that month in Washington . . . on *his* turf . . . his eyes spitting sparks as he branded my factual, though largely philosophic, letter “sarcastic.” If looks could have killed, I would have had only a five-week presidency though I would have fallen in battle for THE CAUSE!

*Item: “Memorandum . . .” late August, 1984.*

“To: Executive Staff”

“Subject: Scheduled Speaking Engagements/Medicare Changes” — heralded a fanning-out of Executives (and me), on invitation of county medical societies in locations over the state, to try to explain the “participating/non-participating” decision while carefully avoiding advocacy of either position lest the FTC would accuse us of collusion! Subsequently, Oklahoma placed a miserable 47th among the states with about 12.8% “participating” — about 1 out of 8.

*Item: “Memorandum . . .” October 31, 1984.*

“To: OSMA officers, Board of Trustees, County Society Presidents . . . The OFPR has notified us that our request for a one month extension before the implementation of the PRO plan has been partially granted.” — set into motion another, smaller,



visitation program during November to attempt to clarify *who* was the villain! Why and what were HCFA's objectives. Most county societies were content to wait and attend one of the two statewide meetings in late November and/or the session of the Hospital Medical Staff Council in mid-November.

Item: (1) "FOR IMMEDIATE RELEASE  
OSMA ISSUES CHELATION  
CAUTION"

(2) "Mr Ken Gaines, General Manager,  
KTOK Radio, January 29, 1985.

"I just listened to the last portion of an interview on your station this morning between Dr Charles Farr and KTOK's Steve Gilbert regarding chelation therapy and the Bio-Genesis Center . . . . To make informed decisions in choosing a physician or particular treatment . . . , the information the public receives must be factual and unbiased . . . . For the health and well-being of your listeners, I ask that

you reexamine . . . editorial policy" — heralded an attempt to spread the word that scientific evidence is lacking that chelation therapy is effective against *anything* but heavy metal poisoning, hypercalcemia, or digitalis toxicity . . . that editorial endorsement and advertising claiming otherwise is callously misleading to the public.

At this time, the battleground seems to be silent though we will continue to seek media exposure of the AMA position.

Hopefully, we shall overcome!

The legacy of unfinished tasks which I pass on to Dr Elvin Amen, your next president, are numerous and quite important as have been alluded to in my report to the Board of Trustees.

It *has been* a fairly good year . . . for which I thank you very much.

Respectfully submitted,  
James B. Eskridge III, MD

## REPORT OF THE PRESIDENT-ELECT to the OSMA House of Delegates

Thank you for this great honor — to be elected to this office by the physicians of Oklahoma almost overwhelms me. You have elevated me to this office to follow in the footsteps of such great men as Jim Eskridge, George Kamp, John McIntyre, Jim Pitts, Floyd Miller, Bill Leebron, Ed Calhoon, Hilliard Denyer, and so many others back to the very beginning of organized medicine in this state — this is our 79th Annual Meeting!

I will miss our beloved Past President, Bill Leebron. Bill first encouraged me to become more active in our organization. His counsel and encouragement kept me motivated to continue to serve OSMA. He will always fill a high place in my memory. His advice and words of encouragement will never be forgotten. Ed Norfleet helped keep me going, too.

I must thank Jim Eskridge, who also encouraged me to become involved, for the pattern he has established for me. I am honored to have followed him through the offices of Chairman of the Board, Vice-President, President-Elect, and now I have his example to guide me in this new opportunity to serve my fellow physicians of Oklahoma. I am looking forward to serving you, the OSMA, and the AMA.

I believe it is worthwhile to have a motto or slogan for service. Let us have, for this year, the overall objective of:

### GET INVOLVED — PARTICIPATE

There is too much discussion by doctors and the media about the deteriorating image of the physician and the art of medicine. Many people talk about what a wonderful person their personal doctor is, but those "other guys" are doing unnecessary surgery, sending patients for unnecessary tests, and then charging too much.

Our government has added to this picture with their "usual, customary, and reasonable" fee schedule and the requests for "second opinions," and claims that doctors are not interested in patients — just in money, DRGs, and PROs.

We must all work to restore the physician to a proper level of esteem. We must *get involved*. We must *participate* in more than just medical activities.

There are so many good avenues for participation by physicians and their families:

*Church* — After all, we do have a pattern to follow in the footsteps of the Great Healer. We have a tremendous opportunity to get involved in church ac-





tivities to help others, and to be helped ourselves by the lessons to be learned from the Bible.

*Community Activities* — Such as civic clubs, Boy and Girl Scout activities, and don't forget Campfire Girls, Cub Scouts, and Brownies.

Get involved, *participate*, offer to serve on committees and as advisors and counselors to these activities. After all — who is better trained to help teach first aid or other health and safety lessons?

Really, isn't it a great satisfaction to see a *youngster catch his first fish or shoot his first quail*? How about those of you who ski? Take a little time and transmit some of your knowledge and skill to a learner.

You cooks — help a youngster learn to bake a fine cake. That child's glow will make you glow, too! Some folks also like hot biscuits!

An extremely important effort must be made in the political field. OMPAC and AMPAC need *you* to help select political officers who will not only uphold the high ideals of our nation, but who will also be aware of true medical care needs of the American

People. We must communicate grassroots philosophy to those in high political offices to maintain high standards of medical care without intrusion and interference from entrenched bureaucracy. We must return quality to the top position, with economy wherever possible, *not* cost cutting at the sacrifice of quality.

Come on in, join us in OMPAC, AMPAC, help us select concerned, qualified people to office in local, state, and national offices. Don't be afraid, give a little more — we need more 99+ and \$200 club members (a luxury evening on the town will cost more than your OMPAC contribution).

However, while participating in such nonprofessional activities, we must never lose sight of our primary professional activities. We must continue to serve those who place their trust in us for care of illness, both physical and mental.

Those of us who are committed to primary care must always be seeking to improve our capabilities to help those in need. We must also be ready to ask for assistance from our specially trained colleagues when we know they can give better help. After all, why did they study those extra years to learn more sophisticated methods of patient care?

Those who have chosen to become specialists must also continue to improve their capabilities in their fields. Continuing Medical Education helps us all give better care.

All of us are being overwhelmed with new material that requires diligent study so it can be used properly in patient care. It will take time, it will take effort. *It can be done!*

Again, I thank you for the trust you have placed in me. With the pattern that has been established, with the help from every one of you, with one of the best staffs of any organization in the United States with our wonderful Auxiliary, with our dedicated office assistants, I know we can go forward with pride in the OSMA for the year 1985-86.

#### GET INVOLVED — PARTICIPATE

We can restore the physician to the friendship of our people.

Respectfully submitted,  
Elvin M. Amen, MD

# MINUTES

## OSMA House of Delegates

### OPENING SESSION

Thursday, May 2, 1985, 9:00 AM

#### I. Call to Order and Opening Remarks

The House of Delegates convened its 79th Annual Session at the Skirvin Plaza Hotel, Oklahoma City, Oklahoma, on May 2, 1985. The Speaker, Larry L. Long, MD, Oklahoma City, called the meeting to order at 9:15 AM.

#### II. Invocation

The invocation was delivered by Michael J. Haugh, MD, Tulsa.

#### III. Introductions

Doctor Long introduced those at the head table: Michael J. Haugh, MD, Chairman of the Board of Trustees; David Bickham, OSMA Executive Director; James B. Eskridge III, MD, President; Elvin M. Amen, MD, President-Elect; John R. Alexander, MD, Vice-President; Robert J. Perryman, MD, Vice-Speaker of the House and Parliamentarian; Ann McWatters and Susan Meeks, Recording Secretaries.

Doctor Long introduced the following special guests: Mr Kevin Walker, AMA Medical Society Relations Officer; J.B. Wallace, MD, Medical Director of the Oklahoma Foundation for Peer Review; Neal Thrift, Executive Director of the Oklahoma Foundation for Peer Review; Keri Hampton, Director of External Review, Oklahoma Foundation for Peer Review; Laverne Dunlap, Acting Executive Director, Oklahoma County Medical Society; Doris Clark, Oklahoma County Medical Society staff; Jack Spears, Executive Director, Tulsa County Medical Society; Edward J. Tomsovic, MD, Dean, University of Oklahoma Tulsa Medical College; Charles B. McCall, MD, Dean, University of Oklahoma College of Medicine; Pam Oster, Auxiliary President; and Karl Stonecipher, MS III, University of Oklahoma College of Medicine.

Doctor Long introduced the following OSMA Past Presidents who were present: Ed L. Calhoon, MD (1970-71); Arnold G. Nelson, MD (1975-76); Orange M. Welborn, MD (1976-77); C.S. Lewis, Jr., MD (1977-78); Floyd E. Miller, MD (1980-81); James B. Pitts, MD (1981-82); John A. McIntyre, MD (1982-83); and George H. Kamp, MD (1983-84).

Doctor Long introduced Roger J. Reid, MD, Ardmore, Past Speaker of the House of Delegates.

At this time, Doctor Long introduced Lanny F. Trotter, MD, General Chairman of the Annual Meeting Committee.

#### IV. Approval of the Minutes of the 1984 Annual Meeting

It was moved that the House accept the minutes of the 1984 Annual Meeting. The motion was seconded and approved.

#### V. Auxiliary Report

Doctor Long recognized Mrs Pam Oster, Auxiliary President, who presented her report, which is included and made a part of the official minutes of the OSMA JOURNAL. She introduced Mary Ann Deen, President-Elect, who spoke about next year's challenges.

#### VI. AMA-ERF Presentations

Mrs Oster introduced Mrs Jan Storms who presented the following checks to the three medical colleges in Oklahoma:

\$25,318.00 to Charles B. McCall, MD, Dean, University of Oklahoma College of Medicine, Oklahoma City.

\$2,325.00 presented to Edward J. Tomsovic, MD, Dean of the University of Oklahoma Tulsa Medical College;

\$1,975.00 was given to Oral Roberts University. (A representative was not present to receive this amount.)

The total amount was \$29,618.00

#### VII. Presentation of Awards

James B. Pitts, Jr., MD, Oklahoma City, spoke briefly in honor of the 1985 recipient of the A.H. Robins Award, John A. Blaschke, MD, Oklahoma City. Then Gary Jones of A.H. Robins presented the award to Doctor Blaschke. Mr Jones also read a "Robinsgram" from the President of A.H. Robins congratulating Doctor Blaschke and telling of their pride for him.

Doctor Blaschke spoke briefly and expressed his thanks at receiving this award.

#### VIII. Announcements

Doctor Long appointed the following committees to assist in the conduct of the meeting:

##### *Parliamentarian*

Robert G. Perryman, MD, Tulsa

##### *Credentials Committee*

Warren L. Felton, MD, Oklahoma City

Rollie E. Rhodes, Jr., MD, Tulsa

Frank K. Buster, MD, Cheyenne

##### *Tellers*

Mary Anne McCaffree, MD, Oklahoma City

Ellis Oster, MD, Ponca City

Norman L. Dunitz, MD, Tulsa

Robert J. Weedn, MD, Duncan

##### *Sergeants-at-Arms*

Chester L. Bynum, MD, Norman

Curtis O. Bohlman, MD, Watonga



#### *Reference Committee I*

John R. Alexander, MD, Chairman, Tulsa  
Frank W. Clark, MD, Ardmore  
H. Clark Hyde, Jr., MD, Oklahoma City  
Frederick A. Kuhn, MD, Oklahoma City  
Mark Kelley, MD, Tulsa  
Gary W. Rahe, MD, Oklahoma City  
George A. Shelton, Jr., MD, Norman  
Boyd O. Whitlock, MD, Tulsa

#### *Reference Committee II*

Sara Reed DePersio, MD, Chairman, Oklahoma City  
Robert Dix, MD, Lawton  
Burdge F. Green, MD, Stilwell  
Richard C. Greyson, MD, Oklahoma City  
Thomas H. Henley, MD, Oklahoma City  
Ralph W. Richter, MD, Tulsa  
Edward J. Tomsovic, MD, Tulsa

#### *Reference Committee III*

Clarence P. Taylor, Jr., MD, Chairman, Ada  
Hal B. Vorse, MD, Oklahoma City  
Stephen K. Cagle, MD, Oklahoma City  
John W. Flynn, MD, Anadarko  
Jack J. Beller, MD, Norman  
Richard L. Winters, MD, Poteau  
Lee N. Newcomer, MD, Tulsa  
Charles H. McCarty, MD, Tulsa

### **IX. Early Announcements**

Announcement was made that the additional information should be inserted in the proper section in their handbooks. Doctor Long instructed them to wear their badges at all times.

Announcement was made that there will be a recess for delegate caucuses after the President's Report.

### **X. President's Report**

Doctor Long introduced James B. Eskridge III, MD, who presented the President's Report.

Doctor Eskridge recalled the happenings which have occurred during his presidency. He stated four tightly filled handbooks of OSMA material line his bookshelves. He specifically mentioned the problems associated with Medicare. He mentioned the letter to Orange M. Welborn, MD, stating Doctor Welborn's appointment as AMA Delegate; the AMA decrease in dues for members in unified states; and OSMA's official statement on Chelation Therapy.

Doctor Eskridge stated that he and the OSMA executive staff had attended many county society meetings explaining Medicare changes and participating/non-participating physicians. Oklahoma placed 47th among the states with about 12.8% choosing to be participating physicians — 1 out of every 8.

He thanked everyone for the assistance he received during his term as President of OSMA.

[The complete text of Dr Eskridge's report appears on page 234.]

### **XI. Recess**

At 9:40 AM the House recessed to allow the county medical societies to caucus for trustee nominations. The House reconvened at 10:10 AM.

At this time, Doctor Long introduced Bruce R. Hinson, MD, OSMA Past President (1954-55).

Doctor Long announced that Charles McCall, MD, Dean of the University of Oklahoma College of Medicine, will be leaving June 30, 1985, to move to Houston, Texas, as Vice-President of Patient Affairs at the M.D. Anderson Hospital. Doctor Long expressed his regret and sadness at Doctor McCall's upcoming departure.

### **XII. Nominations for Elections**

Doctor Long announced only one seconding speech would be allowed per nomination.

He declared the House open for nomination for the position of *President-Elect* (one-year term of office).

Norman L. Dunitz, MD, Tulsa, was nominated by John R. Alexander, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Vice-President* (one-year term of office).

M. Joe Crosthwait, MD, Midwest City, was nominated by Warren Felton, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Secretary-Treasurer* (two-year term of office).

Raymond L. Cornelison, Jr., MD, Midwest City, was nominated by Warren L. Felton II, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Delegate to the AMA (Position III)*.

Ed L. Calhoon, MD, Beaver, was nominated by Rhonald A. Whiteneck, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.



AMA President-Elect H.L. Rogers, Jr., MD, addresses the OSMA House of Delegates.



Nominations were declared open for the position of *Delegate to the AMA (Position V)*.

Victor L. Robards, Jr., MD, was nominated by G. Lance Miller, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Delegate to the AMA (Position VI)*.

Orange M. Welborn, MD, Ada, was nominated by Clarence P. Taylor, Jr., MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Delegate to the AMA (Position VII)*.

James B. Eskridge III, MD, was nominated by Warren Felton, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position I)*.

Frank K. Buster, MD, Cheyenne, was nominated by John A. McIntyre, MD.

John R. Alexander, MD, Tulsa, was nominated by Robert G. Perryman, MD.

Gary F. Strelbel, MD, Oklahoma City, was nominated by Warren Felton, MD.

The nominations were declared closed. (Doctor Long asked Doctors Buster, Alexander, and Strelbel to stand so the Delegates could see them.)

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position II)*.

William O. Coleman, MD, Oklahoma City, was nominated by Warren L. Felton II, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position III)*.

Arnold G. Nelson, MD, Midwest City, was nominated by Warren L. Felton II, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position V)*.

James B. Pitts, Jr., MD, was nominated by Warren Felton, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position VI)*.

Michael J. Haugh, MD, Tulsa, was nominated by Lee N. Newcomer, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position VII)*.

George H. Kamp, MD, Tulsa, was nominated by Rollie E. Rhodes, Jr., MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Trustee (District I)*.

Norman A. Cotner, MD, Grove, was nominated by Ed Norfleet, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District I)*.

Richard E. Martin, MD, Pryor, was nominated by Ed Norfleet, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Trustee (District II)*.

Lanny F. Trotter, MD, Stillwater, was nominated by George Gathers, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District II)*.

Ron M. Kreger, MD, Pryor, was nominated by George Gathers, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Trustee (District III)*.

Joseph W. Stafford, MD, Enid, was nominated by John A. McIntyre, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District III)*.

Theodore H. Fortmann, MD, Okarche, was nominated by James Gerber, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

At this time, Doctor Long announced that in the interest of time, seconding speeches will not be required from this point on.

Nominations were declared open for the position of *Trustee (District IV)*.

Leo Meece, MD, Woodward, was nominated by Ed L. Calhoon, MD.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District IV)*.

Ed L. Calhoon, MD, Beaver, was nominated by Rhonald A. Whiteneck, MD.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Trustee (District V)*.

Thomas J. Lowrey, MD, Yukon, was nominated by Francis Hollingsworth, MD.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District V)*.

Frank K. Buster, MD, Cheyenne, was nominated by Francis Hollingsworth, MD.

There being no other nominations, the nominations were declared closed.

At this time, Norman L. Dunitz, MD, Tulsa, requested to resign from his position as Alternate Trustee (District VII). A motion was made to accept his resignation. The motion was seconded and approved.

Nominations were declared open for the position of *Alternate Trustee (District VII)*.

Rollie E. Rhodes, Jr., MD, Tulsa, was nominated by Dala J.R. Jarolim, MD.

There being no other nominations, the nominations were declared closed.

Nominations for the PLICO Board of Directors (three-year term) were held at this time. The Board of Trustees heard nomination recommendations from the PLICO Board, approved them and now forward them to the House of Delegates for consideration. The slate of nominees is as follows:

J.B. Eskridge III, MD, Oklahoma City  
William O. Coleman, MD, Oklahoma City  
Eugene G. Feild, MD, Tulsa  
Leo Meece, MD, Woodward  
James Miller, MD, Ardmore  
Ed Rice, MD, Oklahoma City  
David M. Selby, MD, Enid, Advisory Member

The motion was made and seconded to accept the above slate of nominees.

There being no other nominations, the nominations were declared closed.

A motion was made that a printed ballot be provided for the PLICO Board of Directors election. The incumbents should be identified as such on the ballot. The motion was seconded and approved.

At this time, Doctor Long turned the meeting over to Robert G. Perryman, MD, Vice-Speaker of the House of Delegates.

### **XIII. Report of the Chairman of the Board of Trustees**

Michael J. Haugh, MD, referred to his report. He noted the Board had its quarterly meeting on Wednesday, May 1. The Supplemental Report was distributed to the House. Five late resolutions were approved by the Board to be brought to the House (Res. 16, 17, 18, 19, 20, and 21). A late Memorial Resolution in honor of Bill McCabe was approved.

### **XIV. Report of the Secretary-Treasurer**

Raymond L. Cornelison, Jr., MD, referred to his report included in the handbooks. He went over the 1985 proposed budget. OSMA is currently worth \$1.1 million.

Doctor Cornelison referred to the Report of the Committee on Appropriations and Auditing. The Report contained these recommendations:

(1) That a thorough review of the OSMA Employees Retirement Plan be conducted and a subsequent report be made to the Board of Trustees; and

(2) That if expenditures cannot be reduced to match income, then a special one-time assessment be levied.

Doctor Cornelison thanks the House for his nomination to another term as Secretary-Treasurer.

The motion was made to accept the Report. The motion was seconded and carried.

### **XV. Presentation of Business to Come Before the House**

Doctor Perryman announced that all information is in the handbooks. No other business will be considered at the Closing Session.

### **XVI. Other Business**

Doctor Perryman asked the physicians to visit the exhibit booths.

Announcement was made that the medical students will be having a meeting Saturday, May 4, 9:00-11:30 AM. Special speakers for the meeting will be Edward N. Brandt, Jr., MD, PhD, Chancellor, University of Maryland at Baltimore; Harrison L. Rogers, Jr., MD, President-Elect of the American Medical Association; and Mark R. Johnson, MD, Editor-in-Chief, JOURNAL of the Oklahoma State Medical Association.



Edward N. Brandt, Jr., MD, PhD, chancellor of the University of Maryland at Baltimore, addresses his audience during the Scientific Program. Dr Brandt also spoke to the University of Oklahoma medical students during their Saturday morning program. Former assistant secretary of health at the DHS, Dr Brandt is a graduate of the University of Oklahoma College of Medicine.

### **XVII. Necrology Report**

Doctor Perryman read the Necrology Report, after which a moment of silence was observed. (A copy of this Report is attached and made a part of these minutes.)

#### *1984-85 Necrology Report*

Martin H. Bartlett, MD  
Austin H. Bell, MD  
Henry G. Bennett, Jr., MD  
William D. Bolene, MD  
Adoniram V. Bowen, MD  
William H. Buchan, MD  
Lee K. Emenhiser, MD  
Leon Coleman Freed, MD  
Charles W. Freeman, MD  
Ella Mary George, MD  
Clark H. Hall, MD  
Grace Clause Hassler, MD  
Owen L. Hill, MD  
Ingvald John Haugen, MD  
Paul Kernek, MD  
William M. Leebron, MD

E.C. Lindley, MD  
Emmett Herbert Lindley, MD  
Larry L. Lowry, MD  
Earl M. Lusk, MD  
Louis A. Martin, MD  
Glen Webster McDonald, MD  
Hugh H. Monroe, MD  
Kirk T. Mosley, Jr., MD  
Solomon Papper, MD  
Oliver H. Patterson, MD  
Seth D. Revere, MD  
Don D. Sullivan, MD  
Floyd L. Waters, MD  
Carryl W. Wiggins, MD  
Harry Wilkins, MD

### **XVIII. Adjournment**

The Opening Session of the House of Delegates was adjourned at 11:25 AM.

Recorded by Ann McWatters and Susan Meeks.



# MINUTES

## OSMA House of Delegates

### CLOSING SESSION

Saturday, May 4, 1985, 12:30 PM

#### I. Call to Order

The Closing Session of the 79th Annual Meeting of the House of Delegates was called to order by Speaker Larry L. Long, MD, Oklahoma City, at 12:40 PM in Ballroom Meeting Room A of the Skirvin Plaza Hotel in Oklahoma City.

#### II. Report of the Credentials Committee

Credentials Committee Chairman, Dr. Warren L. Felton II, Oklahoma City, announced that a quorum of Delegates was present.

#### III. Invocation

Victor L. Robards, Jr., MD, Tulsa, delivered the invocation.

#### IV. Special Items

Doctor Long asked Dr J.B. Eskridge III, outgoing President, to introduce Harrison L. Rogers, Jr., MD, Atlanta, GA, President-Elect of the AMA.

Doctor Rogers commended the OSMA on its delegation. He commented on various changes in the medical profession, and noted that the product American physicians deliver today is the gold standard for the world. He also discussed ethical and cost problems of today.

Doctor Rogers then discussed the malpractice issue, and noted that the AMA will be working hard for tort reform. He also stressed the importance of membership in the PAC movement, and then answered questions from the floor.

Doctor Long introduced MS Sally Berger and MS Karl Stonecipher, Medical Student Representatives to the OSMA House of Delegates.

Doctor Long also paid special recognition to the AAMA National President, Janet Hensinger, Lexington, KY, and her host, Jane Devine, Tulsa.

#### V. Presentations

*A. Charlotte S. Leebron Memorial Award.* Doctor Long introduced Dr Mark R. Johnson, Editor-in-Chief of the OSMA JOURNAL. Doctor Johnson presented checks of \$250 each to the winners of the Charlotte S. Leebron Memorial Trust Fund Award for the Best Scientific Paper published in the JOURNAL for 1984. This year's award went to Mark H. Mellow, MD, and Gretchen A. McCoy, MD, both of Oklahoma City, for their paper, "Endoscopic Laser Therapy in the Palliative Treatment of Colorectal Carcinoma: A Case Report." Doctors Mellow and McCoy expressed their appreciation.

*B. Presentation to J.B. Eskridge III, MD.* Doctor Johnson then presented to Doctor Eskridge a personal bound volume of the May 1984 to April 1985 issues of the JOURNAL, and expressed his thanks on behalf of the Association and the Editorial Board.

*C. Recognition of Jack Spears, TCMS Executive Director.* Norman L. Dunitz, MD, Tulsa, expressed his appreciation on behalf of the Tulsa County Medical Society to Mr Jack Spears, Executive Director, who will soon retire.

*D. Edward K. Norfleet, MD, Vinita.* Floyd F. Miller, MD, Tulsa, presented to Doctor Norfleet a plaque on behalf of the House of Delegates, expressing appreciation for his being a friend of medicine and the OSMA. Doctor Norfleet then conveyed his thanks.

#### VI. Report of the President-Elect

Elvin M. Amen, MD, Bartlesville, noted his official presentation would be distributed to the House. (A copy of the Report of the President-Elect is made a part of the official minutes in the OSMA JOURNAL.) Doctor Amen stated his motto for the year would be "Get Involved — Participate."

[The complete text of Dr Amen's report appears on page 235.]

#### VII. Annual PLICO Shareholders Meeting

Doctor Long recessed the House of Delegates and called to order the meeting of the PLICO Shareholders. He then introduced C. Alton Brown, MD, Oklahoma City, President and Chairman of the PLICO Board, to present his report. (A copy of the PLICO Report is made a part of the official minutes in the OSMA JOURNAL.)

Doctor Brown stressed the importance of reinsurance and noted it is essential to protect the financial integrity of PLICO. He informed the House that the increases in premiums that occurred in both professional liability and accident and health last year and this year were intended to preserve the financial strength of PLICO and pay additional reinsurance costs.

Doctor Brown also discussed the new eight class system, and stated that this fall PLICO representatives will call on every county society to thoroughly explain this new system.

It was then moved, seconded, and carried that the meeting of the PLICO Shareholders be adjourned. The Chair then called to order the House of Delegates.

#### VIII. Elections

Doctor Long introduced the appointed tellers: Mary Anne McCaffree, MD, Oklahoma, Chairperson; Ellis Oster, MD, Ponca City; Norman L. Dunitz, MD, Tulsa; and Robert J. Weedn, MD, Duncan.

Doctor Long reviewed the list of uncontested nominees: Norman L. Dunitz, MD, Tulsa — *President-Elect*  
M. Joe Crosthwait, MD, Midwest City — *Vice-President*

Raymond L. Cornelison, Jr., MD, Midwest City — *Secretary-Treasurer*



Ed L. Calhoon, MD, Beaver — *AMA Delegate (Position III)*  
 Victor L. Robards, Jr., MD, Tulsa — *AMA Delegate (Position V)*  
 Orange M. Welborn, MD, Ada — *AMA Delegate (Position VI)*  
 J.B. Eskridge III, MD, Oklahoma City — *AMA Delegate (Position VII)*  
 William O. Coleman, MD, Oklahoma City — *AMA Alternate Delegate (Position II)*  
 Arnold G. Nelson, MD, Midwest City — *AMA Alternate Delegate (Position III)*  
 James B. Pitts, Jr., MD, Oklahoma City — *AMA Alternate Delegate (Position V)*  
 Michael J. Haugh, MD, Tulsa — *AMA Alternate Delegate (Position VI)*  
 George H. Kamp, MD, Tulsa — *AMA Alternate Delegate (Position VII)*

*Trustee District I:* Craig, Delaware, Mayes, Nowata, Ottawa, Rogers, and Washington Counties

Trustee: Norman A. Cotner, MD, Grove

Alternate Trustee: Richard E. Martin, MD, Pryor

*Trustee District II:* Kay, Noble, Osage, Pawnee, and Payne Counties

Trustee: Lanny F. Trotter, MD, Stillwater

Alternate Trustee: Ron M. Kreger, MD, Ponca City

*Trustee District III:* Garfield, Grant, Kingfisher, and Logan Counties

Trustee: Joseph W. Stafford, MD, Enid

Alternate Trustee: Theodore H. Fortmann, MD, Okarche

*Trustee District IV:* Alfalfa, Beaver, Cimarron, Dewey, Ellis, Harper, Major, Texas, Woods, and Woodward Counties

Trustee: Leo Meece, MD, Woodward

Alternate Trustee: Ed L. Calhoon, MD, Beaver

*Trustee District V:* Beckham, Blaine, Canadian, Custer, and Roger Mills Counties

Trustee: Thomas J. Lowrey, MD, Yukon

Alternate Trustee: Frank K. Buster, MD, Cheyenne

*Trustee District VII:* Tulsa County (to fill the vacancy left by Norman L. Dunitz, MD, as he is a nominee for President-Elect)

Alternate Trustee: Rollie E. Rhodes, Jr., MD

Doctor Long declared the above slate of nominees duly elected.

Doctor Long then announced that there are two contested races. AMA Alternate Delegate Position I has three nominees: John R. Alexander, MD, Tulsa; Frank K. Buster, MD, Cheyenne; and Gary F. Strebel, MD, Oklahoma City.

The PLICO Board of Directors has five available positions and seven nominees: J.B. Eskridge III, MD, Oklahoma City (incumbent); Eugene G. Feild, MD, Tulsa (incumbent); David M. Selby, MD, Enid (incumbent); William O. Coleman, MD, Oklahoma City; Leo Meece, MD, Woodward; James V. Miller, MD, Ardmore; and Edwin E. Rice, MD, Oklahoma City.

Ballots were distributed for the vote. Doctor Long noted that once the tellers have tallied the vote, he would announce the winners during the progression of the meeting.

## IX. Reference Committee Reports

Doctor Long stated the Reference Committee Reports

would be governed by Robert's Rules of Order. A Delegate could speak once for or against a question. Variation from that would be at the Chair's discretion. Doctor Long asked that each Delegate state his name and county medical society when speaking before the House, and noted that a recommendation by a Reference Committee is automatically introduced as a motion and does not require a second.

The Reference Committee Reports considered by the House are attached and made a part of the official minutes included in the July, 1985, issue of the OSMA JOURNAL.

### REPORT OF REFERENCE COMMITTEE I

Presented by John R. Alexander, MD, Tulsa

Reference Committee I approved the following items without amendment:

*Item 1. Report of the Board of Trustees and Supplemental Report of the Board of Trustees.* The Reference Committee Report explained that these two reports are a brief review of actions taken by the Board of Trustees during its meetings throughout the year.

*Item 2. Report of the Secretary-Treasurer and Report of the Committee on Appropriations and Auditing.* The Reference Committee noted this information includes a detailed accounting of the Association's financial operations, and recognized the Trustees for the amount of time spent each year on behalf of the Association. The report also takes note of OSMA's healthy financial condition.

There was considerable discussion concerning the Reference Committee's Recommendation D, referring Recommendation #2 of the Committee on Appropriations and Auditing to the Board of Trustees for implementation, when necessary, whereby a special one-time assessment would be levied if expenditures could not be reduced to match income.

A substitute motion was moved and seconded, whereby the OSMA would not have any assessment. It was noted that if the first motion were accepted, it would give the Board of Trustees the latitude to achieve a balanced budget. After further discussion, a vote was called on the substitute motion. A division was then called, and a vote was taken by standing. The substitute motion was defeated — 51 voted in favor of the motion, and 58 were opposed.

The House then voted on the original motion, concerning adoption of Recommendation D, as well as Item 2 as a whole. The motion carried.

Doctor Long interrupted the Reference Committee business to announce that a runoff vote would need to be taken between Gary F. Strebel, MD, Oklahoma City, and John R. Alexander, MD, Tulsa, for AMA Alternate Delegate Position I.

*Item 3. Report A of the Board of Trustees — Penn Square Bank.*

*Item 4. Membership Report.*

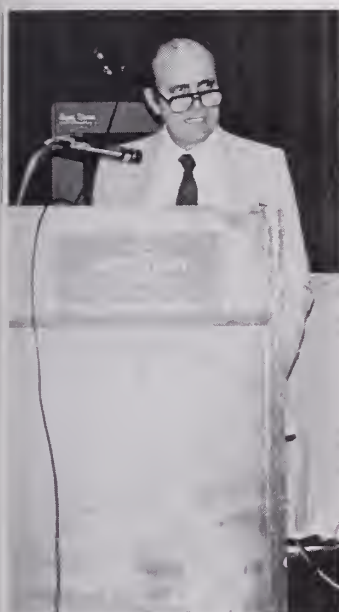
*Item 5. Report of the Council on Long-Range Planning and Development.* The Reference Committee commended George H. Kamp, MD, Chairman, for his exceptional leadership of this council.

*Item 7. Report of the Physicians Liability Insurance Company.* The Reference Committee commended the members of the PLICO Board for the exemplary manner in which they conducted the company's business.

*Item 8. Report of the OSMA Auxiliary.* The Reference Committee commended Mrs Pam Oster, Auxiliary President for 1984-85, for her exceptional leadership and dedication.

*Item 13. Resolution 17 — For-Profit Service Corporation.* Reference Committee I approved the following items as amended:

*Item 6. Report of the Constitution and Bylaws Committee.* Doctor Alexander proposed an amendment, whereby this Report would be considered item by item, rather than adopting it as a whole. The House then approved adoption of (A) the Physician Recovery Committee and housekeeping amendments; (B) the creation of a Hospital Medical Staff Section; (C) the creation of a Resident Section; and (D) the creation of a Student Section.



Presenting "Rationing of Health Care: Choices to Be Made When Resources Are Limited" during the Scientific Program is Everett Rhodes, MD, assistant surgeon general and director of the Indian Health Service. Dr Rhodes is a graduate of the University of Oklahoma College of Medicine.

*Item 9. Resolution 4 — Outpatient Psychiatric Services.* The Reference Committee recommended the following Substitute Resolution in lieu of Resolution 4:

"Resolved, That the House of Delegates hereby requests the Board of Directors of PLICO to modify its PLICO Health policy to include broader coverage for outpatient psychiatric services; and be it further

"Resolved, That the Board of Directors of PLICO present a proposal to the House of Delegates in 1986 to include outpatient psychiatric care under PLICO coverage."

After discussion, It was then moved, seconded, and carried that the word "broader" be inserted between the words "include" and "outpatient" on the next to the last line of the above Substitute Resolution.

*Item 11. Resolution 8 — Increased Professional Support of OMPAC and Resolution 15 — OMPAC Membership.* The Reference Committee considered the above resolutions as one item, and recommended that the following Substitute Resolution be adopted in lieu of Resolutions 8 and 15:

"Resolved, That the Oklahoma State Medical Association encourage the Oklahoma Medical Political Action

Committee to mount an intensive campaign designed to increase physician giving and the amount of contributions; and be it further

"Resolved, That OMPAC be encouraged to hold meetings for physicians in each county of Oklahoma at which the objectives of the organization and its programs can be explained; and be it further

"Resolved, That the Council on State Legislation and the Council on Governmental Activities encourage that every physician member of the OSMA contribute the minimum membership of fifty dollars (\$50.00) to OMPAC and wholeheartedly urge all members to increase their membership where feasible."

*Item 12. Resolution 14 — Impaired Physicians.* The Reference Committee recommended amending this Resolution, whereby on Line 18 the word "delicensure" would be stricken and replaced with the word "disciplinary."

It was moved, seconded, and carried that Resolution 14 be further amended so as to read on Line 18, "disciplinary/rehabilitative."

*Item 14. Resolution 18 — PLICO Appeal Mechanism.* The Reference Committee recommended amending Resolution 18, whereby on Line 19 the word "second" is deleted.

Reference Committee I rejected the following item:

*Item 10. Resolution 6 — University of Oklahoma Tulsa Medical College.* The Reference Committee heard testimony against this resolution, but heard no testimony in support of it. Reference Committee I recommended that Resolution 6 not be adopted.

It was moved, seconded, and carried that the House of Delegates adopt the Report of the Reference Committee I as a whole.

Doctor Long then announced that Dr John R. Alexander, Tulsa, was duly elected as AMA Alternate Delegate Position I.

## REPORT OF REFERENCE COMMITTEE II

Presented by Sara Reed DePersio, MD, Oklahoma City.

Reference Committee II approved the following items without amendment:

*Item 1. Report of the President.* The Reference Committee conveyed its most sincere gratitude and appreciation to James B. Eskridge III, MD, for his excellent leadership the past year.

*Item 2. Report of the President-Elect.*

*Item 3. Report of the Council on Professional and Public Relations.* The Reference Committee commended the Council for a good job, favored the production of the documentary film, and encouraged the Council to continue its innovative thinking in order to promote a more positive physician image.

*Item 5. Report of the Council on Medical Education.* The Reference Committee expressed its appreciation to the Council for effectively carrying out its assigned duties.

The Reference Committee stressed the importance of the "white paper" attached to the Council Report, which was developed and presented to the Advisory Committee to the State Regents for Higher Education.

*Item 6. Report of the Council on Medical Services.* The Reference Committee conveyed its appreciation to the Council for the work it has done in 1984-85.



*Item 7. Report of the Council on Hospital Medical Staffs.* The Reference Committee thanked the Chairman and the Council members for faithfully carrying out their assigned tasks.

*Item 8. Report of the Oklahoma Foundation for Peer Review.* The Reference Committee was impressed to see the strides the Foundation has made in implementing the PRO plan.

*Item 10. Report of the JOURNAL of the Oklahoma State Medical Association.* The Reference Committee thanked the editor and editorial staff of the OSMA JOURNAL for again producing an excellent publication.

*Item 13. Resolution 5 — Mental Health Programs.*

*Item 14. Resolution 7 — Truth in Advertising.*

*Item 16. Resolution 16 — Reactivation of Fee Review Committee.*

Reference Committee II approved the following items as amended:

*Item 4. Report of the Council on Public and Mental Health.* The Reference Committee expressed its gratitude for the manner in which the Council carried out its assigned duties.

The Reference Committee recommended the following change:

On Page 3, Line 4, Section C, after the title "Maternal Mortality Committee," delete Lines 4 through 6 and insert "The annual report was submitted to the Council."

*Item 9. Report of the Ad Hoc Committee on OSMA/OFPR Relations.* Doctor DePersio proposed an amendment, whereby the original Reference Committee report be changed, striking on Lines 43-44 the phrase "be referred back to the board of Trustees for reconsideration" and inserting the following, so as to read from Line 43:

"4 and that Recommendation 4 be deleted from the Report, and that the OFPR Board carefully and cautiously consider private review contracts for implementation so that they will be performed and executed in the best interests of patient care in Oklahoma, and that the evaluation of the performance of these contracts be included in the reports of OFPR to the OSMA."

After discussion, it was moved and seconded to amend Item 9 of the Report of Reference Committee II as noted above. A vote was taken, and the motion carried.

*Item 11. Resolution 1 — Ending Tobacco Subsidies.* The Reference Committee recommended that the resolution be amended, and the intent not changed, by inserting the following on Page 1, between Lines 9 and 10:

"Whereas, There is mounting evidence that smokeless tobacco is associated with pre-cancer and cancerous oral disease; and"

*Item 15. Resolution 10 — Radial Keratotomy.* The Reference Committee recommended correction of the typographical error noted on Line 14, whereby the word "access" would be changed to "assess."

Reference Committee II rejected the following item:

*Item 12. Resolution 3 — Prohibition of Smoking in Patient Areas.* The Reference Committee supported the intent of this resolution, but did not feel that it is workable, and therefore recommended that Resolution 3 not be adopted.

It was moved, seconded, and carried that the House of Delegates adopt the Report of Reference Committee II as a whole.

Doctor Long then announced that the House of Delegates would need to approve three memorial resolutions: Mrs Dee Hampton, former Executive Director of the Oklahoma County Medical Society; William M. Leebron, MD, Elk City; and Mr Bill McCabe, former Alumni Association Director at OUHSC.

It was moved, seconded, and carried that the House approve the three memorial resolutions noted above.

[The complete text of the memorial resolutions appears on page 245.]

Doctor Long then announced the winners of the PLICO Board election, and proclaimed them duly elected:

J.B. Eskridge III, MD, Oklahoma City

Edwin E. Rice, MD, Oklahoma City

David M. Selby, MD, Enid

William O. Coleman, MD, Oklahoma City

Eugene G. Feild, MD, Tulsa

(David Bickham, OSMA Executive Director, is automatically part of the PLICO Board, as written in the PLICO bylaws.)



D. Robert McCaffree, MD, associate professor of medicine at the University of Oklahoma Health Sciences Center, conducts a short course on pulmonary disease.

#### REPORT OF REFERENCE COMMITTEE III

Presented by Clarence P. Taylor, Jr., MD, Ada

Reference Committee III approved the following items without amendment:

*Item 1. Report of the Council on Governmental Activities.* The Reference Committee heard an in-depth report from Dr Perry A. Lambird, Council Chairman, regarding the status of federal legislation pertaining to the medical



profession. The Reference Committee extended sincere appreciation to Doctor Lambird and the Council members and staff for their diligent efforts with Congress.

*Item 2. Report of the Council on State Legislation.* The Reference Committee applauded the innovative and successful programs initiated by the Council, Dr William L. Hughes, Council Chairman, and Ms Otie Ann Carr, Director of State Legislation. It was noted that OMPAC membership is an extremely effective ingredient for legislative success.

*Item 3. Report of the Council on Member Services.* The Reference Committee conveyed special congratulations for Dr William O. Coleman's work as Chairman and the members of the Council for their excellent work and concern in keeping their programs self-sustaining.

*Item 4. Report of the Oklahoma Medical Political Action Committee.* The Reference Committee stressed the importance of OMPAC to the medical profession, their patients, and their future.

*Item 5. Report of the Physician Recovery Committee.* The Reference Committee commended J. Darrel Smith, MD, Interim Medical Director of the program, and the members of the Physician Recovery Committee, for the enormous progress made during the past year and the goal of expanding the scope of this program in the future.

*Item 6. Resolution 2 — Proposed User Fee for Tobacco Products.* The Reference Committee recommended that this resolution be adopted and that special consideration be given to petitioning Congress for a national tobacco user tax.

*Item 7. Resolution 9 — Opposition to Hospital Pre-Admission Certification.* The Reference Committee recommended this resolution be adopted, and encouraged the OSMA to petition Congress in opposition to pre-admission certification, as it is presently a law.

*Item 8. Resolution 11 — Federal Regulations.*

*Item 9. Resolution 12 — Liability Insurance Carriers and Resolution 13 — Liens Against Insurance Proceeds.* The Reference Committee noted that both resolutions resolved to seek appropriate amendments to Oklahoma law in similar fashions, and that present state legislation, HB 1545, includes an amendment which concurs with the intent of these resolutions. The Reference Committee recommends adoption of both Resolution 12 and 13.

*Item 10. Resolution 19 — HCFA Demonstration Project.* The Reference Committee commended the efforts of Senator Don Nickles and his staff for securing from HCFA a tentative commitment to consider an Oklahoma Demonstration on alternative physician reimbursement under Medicare.

Doctor Taylor noted that originally, Line 14 on Page 2 would have been deleted from the resolution, but noted that it needed to be left intact as written. Thus, Resolution 19 was adopted as a whole and not amended.

*Item 11. Resolution 20 — Funding of Medical Education through Medicare.*

*Item 12. Resolution 21 — Professional Liability Insurance.*

It was moved, seconded, and carried that the House adopt the Report of Reference Committee III as a whole.

Doctor Long turned the meeting over to Robert G. Perryman, MD, Vice-Speaker of the House.

## X. Other Business

Doctor Perryman announced that the PLICO Forum will meet in the Regency Room immediately upon adjournment of the House.

Doctor Perryman then congratulated Irwin H. Brown, MD, Chairman of the Scientific Program Committee, and Lanny F. Trotter, MD, General Chairman of the 1985 Annual Meeting, for their diligent efforts in producing a successful annual meeting.

Mr David Bickham, OSMA Executive Director, noted that a copy of HB 1223 had been distributed prior to the Closing Session, and asked the Delegates to study this bill carefully. He noted that the OSMA staff is diligently working with the author to make modifications to this bill, and urged the delegates to call their representatives and let them know their stand on this particular issue.

The bill is introduced as "An act relating to professions and occupations; prohibiting certain persons from collecting fees for medical diagnostic tests under certain conditions; allowing certain persons to raise an affirmative defense; prohibiting certain persons from committing acts with respect to medical tests and records; providing exceptions; designating persons to whom notice should be given; providing for codification; and providing an effective date."

## XI. Adjournment

It was moved, seconded, and carried that the Closing Session of the 79th Meeting of the House of Delegates adjourn. The House of Delegates adjourned at 3:00 PM.

Recorded by Toni Leverett, Recording Secretary

## MEMORIAL RESOLUTION MRS DEE HAMPTON

Introduced by the OSMA Board of Trustees

WHEREAS, Dee Hampton, for 22 years a dedicated and loyal employee of the Oklahoma County Medical Society, died February 12, 1985; and

WHEREAS, For 8 years Dee served with distinction as Executive Director of OCMS and the Oklahoma Clinical Society; and

WHEREAS, Throughout her career with medicine she maintained a demeanor and decorum so pleasant and disciplined as to be enviable; and

WHEREAS, Dee's ability to work with physicians and colleagues in a caring manner was one of her greatest assets; and

WHEREAS, Her devotion and loyalty to medicine was second only to her love and dedication to her family and friends; and

WHEREAS, The Oklahoma County Medical Society specifically and Oklahoma medicine have lost a great lady and beloved friend, now therefore be it

*Resolved*, That the Oklahoma State Medical Association House of Delegates express to the family and friends of Dee Hampton our deepest sympathy and sense of loss as a result of the death of this great friend and colleague of medicine.

## MEMORIAL RESOLUTION WILLIAM M. LEEBRON, MD

Introduced by the OSMA Board of Trustees

WHEREAS, William M. Leebron, MD, Elk City, Oklahoma, President of the OSMA in 1979-80, died March 22, 1985; and

WHEREAS, Doctor Leebron's medical practice and his dedication to the profession were an inspirational example for his friends and colleagues; and

WHEREAS, His devotion to his community and his adopted state were and are evidenced by his many contributions of both time and money; and

WHEREAS, His demonstrated interest and love for family, friends, and patients was a constant characteristic; and

WHEREAS, All who knew Bill Leebron have lost a close and dear friend; now therefore be it

*Resolved*, That the House of Delegates of the Oklahoma State Medical Association, in session on May 2, 1985, hereby expresses its sincere and heartfelt sympathy to his family, his colleagues, his friends, and his patients.

## MEMORIAL RESOLUTION BILL McCABE

Introduced by the OSMA Board of Trustees

WHEREAS, Bill McCabe, Oklahoma City, Director of the University of Oklahoma College of Medicine Alumni Association, 1978-1984, died on December 14, 1984; and

WHEREAS, Mr McCabe served both the University and its medical graduates with diligence and dedication; and

WHEREAS, Under his leadership, the Alumni Association has achieved a strength and dynamism that will continue long into the future; and

WHEREAS, The Physicians of Oklahoma have lost a valued friend and ally; now therefore be it

*Resolved*, That the House of Delegates of the Oklahoma State Medical Association express to the family and friends of Bill McCabe our deepest sympathy and sense of loss as a result of the death of this great friend and colleague of medicine.



Delegates and visitors enjoy refreshments in the Exhibit Hall during one of two exhibitors' receptions. The Exhibit Hall was the hub of activity during Annual Meeting, with fresh coffee available throughout the day to casual browsers and busy physicians and executives. Light lunches were available each day as well.



# REPORTS to the OSMA House of Delegates Referred to Reference Committee I

## Report of the BOARD OF TRUSTEES

Subject: **Annual Report**  
Presented by: Michael J. Haugh, MD, Chairman  
Referred to: Reference Committee I

### Introduction

The Board of Trustees of the OSMA has completed three of its regular quarterly meetings for organizational year 1984-85, in addition to one special board meeting. The fourth, or annual meeting of the board is being held in conjunction with the 1985 annual meeting of the association. The proceedings of the annual board meeting are contained in the Supplemental Report of the Board of Trustees.

During the past year, the board met in special session on June 10, and in regular sessions on August 12 and November 11, 1984, and February 17, 1985. A quorum was certified for each meeting with an average of 8 officers, 16 trustees or alternate trustees, and 11 AMA delegates or alternate delegates present.

### Special Session

The Board of Trustees met in special session on June 10 to hear PLICO insurance appeals from three physicians. Under the OSMA's current arrangement with PLICO, a recommendation is made by the association's Underwriting Committee (a part of the Council on Member Services) to the PLICO Board of Directors. The PLICO Board then makes a decision regarding the insurance, but the agreement specifies that any OSMA physician member can appeal that decision directly to the Board of Trustees of the association.

### Physicians Recovery Committee

The 1984 House of Delegates of the OSMA gave approval to the conversion of the association's "Physicians Committee" over to a "Physicians Recovery Committee." (The 1985 House of Delegates will consider the necessary bylaws change to formalize this conversion.) The change was made at the recommendation of the association's Physicians Committee and included a recommendation that the new program should employ a director to supervise the new committee's activities.

J. Darrel Smith, MD, serving as chairman of the new Physicians Recovery Program, was also approved to serve as interim director for a period of one year.

### Council and Committee Reports

Customarily, the Board of Trustees hears reports from all of the OSMA councils and committees during each meeting. During 1984-85, most of the association business that came before the Board of Trustees came through one of these groups. Since these groups also report directly to the

House of Delegates on their year's activities, their reports to the board will not be reproduced here.

From the length and breadth of each report, however, it can be seen that the Board of Trustees spent a great deal of time working with and supervising the council and committee activities to give the association one of its most active years.

### Medical Students

The association continued its support of the Medical Student Communications Program during 1984-85. This included sponsoring picnics in both Oklahoma City and Tulsa for medical students and support for a new program, "OU Advanced Seminars" developed by Wilson Steen, PhD, of the Health Sciences Center and featuring non-medical topics for young physicians and medical students. Scheduled throughout the year, the first seminar in the series featured Senator Henry Bellmon, while Robert Fulton, Director of the Oklahoma Department of Human Services, spoke at the second program. Approximately 6 seminars were conducted in all during 1984-85.

### Auxiliary

The Oklahoma State Medical Association Auxiliary gave a full report to each meeting of the Board of Trustees. Their activities were many and varied beginning with a 2-day confluence held in September with special emphasis on the subject of establishing health improvement programs in elementary schools.

The Auxiliary worked closely with the organ donor project and gave it much publicity through the placement of special posters in tag agencies throughout the state. In addition, it developed and distributed two public service announcements regarding childhood immunizations that were used by radio stations throughout the state and were taped for television and used in Oklahoma City and Tulsa.

The Auxiliary's "Doctors Wives' Day at the Legislature" was held February 27. Key speakers were Senate President Pro Tempore Rodger Randel and Rebecca Hamilton, Chairman of the House of Representatives Public Health Committee.

The board approved funding for two auxiliary projects for 1985-86: assistance in obtaining a speaker for the Auxiliary's 1985 Fall Confluence and funding of the "Medi-File Card" project.

For the Medi-File Card project, the association will pay the cost of printing 100,000 cards for distribution by the auxiliary to physician offices. These cards are issued to senior citizens over the age of 65 and lists their specific medications. The card can then be carried by the patient and referred to whenever needed.

### PLICO and OFPR

Both the Physicians Liability Insurance Company and the Oklahoma Foundation for Peer Review gave a status



report to the Board of Trustees at each of its meetings. Since both of the organizations report directly to the House of Delegates, their individual board reports will not be detailed here.

#### **AMA-GTE Project**

During its annual meeting in 1984, the Board of Trustees authorized the association to enter into a contract with GTE to become a distributor for the AMA-GTE project known as "MINET." This is a national computerized information network allowing physicians to access at least 6 data bases on such topics as disease information, drug information, current procedural terminology information, clinical literature and socioeconomic literature. In addition, it also contained what is known as an "electronic mail service" allowing any physician on the network to directly contact any other physician, state medical association, or the American Medical Association.

In late August, the association did forward a signed contract to GTE for consideration. Hearing no response and following several inquiries, the association's staff was informed by GTE in November that there was a major change being made in the program, i.e., the AMA had entered into an agreement with GTE to waive the \$100 initial sign-up fee for any AMA member to get on the network.

The official announcement of the fee waiver was made in February of this year. At that time, the association's staff recost-accounted the project and determined that without the \$100 sign-up fee, it would not be economically feasible for the association to become a distributor for the project. Although the distributors did receive a small percentage of the monthly users fee, this would not be enough to offset the initial publicity and promotion necessary to sell the service to individual members and would come nowhere close to furnishing enough money for the association to hire, even part time, someone to install the system in a physician's office and train his or her personnel to utilize it.

The Council on Member Services recommended to the board that the project be abandoned for now.

#### **Life Membership Awards**

The following physicians have been awarded life membership in the Oklahoma State Medical Association through application from component societies, and with the approval of the association's Board of Trustees:

*August 12, 1984*

James C. Smith, Jr., MD, Tulsa

*November 11, 1984*

Vance A. Bradford, MD, Oklahoma City

Manuel Brown, MD, Tulsa

Vernon D. Cushing, MD, Oklahoma City

Ross P. Demas, MD, Lawton

Robert P. Dennis, MD, Lawton

Charles E. Leonard, MD, Oklahoma City

Joseph N. Mitchell, MD, Lawton

Ralph L. Nicholson, MD, Tulsa

Thurman Shuller, MD, McAlester

*February 17, 1985*

Sumner Y. Andelman, MD, Tulsa

Paul N. Atkins, Jr., MD, Tulsa

Howard W. Cohenour, MD, Tulsa

Rayburne W. Goen, Sr., MD, Tulsa

James D. Loudon, MD, Shawnee

Mason R. Lyons, MD, Tulsa

Matthew B. Moore, MD, Tulsa

James H. Neal, Jr., MD, Tulsa

Dale E. Newman, MD, Tulsa

Herbert S. Orr, MD, Inola

John D. Osborn, MD, Muskogee

George E. Parkhurst, MD, Tulsa

Respectfully submitted,

Michael J. Haugh, MD

Chairman

OSMA Board of Trustees

### **Supplemental Report of the BOARD OF TRUSTEES**

Subject: **Supplemental Report**

Presented by: Michael J. Haugh, MD, Chairman

Referred to: Reference Committee I

Mr Speaker and Members of the House:

The Board of Trustees met at its Annual Meeting Wednesday, May 1, and this supplemental report identifies for the Delegates the actions taken for the board at this meeting. This report will be referred to Reference Committee I to be considered along with the Annual Report of the Board of Trustees, which was included in the Delegate's Handbook. The board meeting was called to order by Michael J. Haugh, MD, Chairman, at 2:00 pm with an invocation by Elvin M. Amen, MD, introductions of guests and announcement that this was the 79th Annual Meeting of the Oklahoma State Medical Association.

The board approved the minutes of its February 17 meeting as written.

J. B. Eskridge III, MD, President, gave his final report to the board as the association's highest elected official. He expressed his sincere thanks for the opportunity of serving the association in this capacity and pledged his support to Dr Elvin M. Amen, incoming President.

Dr Raymond L. Cornelison, Jr., Secretary-Treasurer, presented his financial report in detail. He stated that the full report is included under Reference Committee I in the handbooks. Dr Cornelison prefaced his report by stating that the association's financial condition was good, and that after adjustments, the income exceeded expenses by almost \$96,000. The original budget proposed projected a deficit in excess of \$120,000. However, he stated that the proposed budget anticipates a deficit of almost \$100,000. Special efforts have been made to reduce expenditures to bring them more in line with income.

Dr Cornelison brought special attention to the AMA travel expenses, an item that has been reduced from the original budget by approximately \$12,000. To accomplish the savings, existing travel policy would have to be changed to provide that, for one of the AMA meetings, the delegation

would be reduced to Delegates, Alternate Delegates, the President, and the Executive Director, who would travel at tourist class or the lowest air fare possible. He also identified other reductions.

In addition to the other budget reductions included in the Secretary-Treasurer's Report, it was recommended to the board by the Committee on Appropriations and Auditing that, rather than resort to deficit financing, the board should support a special one-time assessment (approximately \$32 per member) to cover the proposed deficit.

The board accepted the recommendations of the Secretary-Treasurer and the recommendations in the Report of the Committee on Appropriations and Auditing.

Dr Lanny Trotter, General Chairman of the Annual Meeting, made a few brief comments and thanked the Annual Meeting Planning Committee members for their excellent job done.

Mrs Pam Oster, outgoing President of the OSMA Auxiliary, presented her final report to the board, and commented on the Auxiliary's accomplishments for the past year. Her report is included in Reference Committee I.

Mrs Mary Ann Deen, incoming Auxiliary President, noted the theme for the coming year is the image of physicians and their spouses. She thanked the board for its continued support.

The PLICO Board requested that PLICO Board Members whose terms expire this year be submitted for approval by the Board of Trustees, to be forwarded to the House of Delegates for re-election to a term of three years. Those eligible for re-election are:

J. B. Eskridge III, MD, Oklahoma City

Eugene G. Feild, MD, Tulsa

David M. Selby, MD, Enid, Advisory Board Member  
Nominees for two vacancies (Dr William M. Leebron, Elk City, deceased, and Dr Marvin K. Margo, Oklahoma City, who will not stand for re-election) are as follows:

William O. Coleman, MD, Oklahoma City

Ed E. Rice, MD, Oklahoma City

Leo Meece, MD, Woodward

The Board of Trustees approved the following nominees to serve on the Board of Directors for the Oklahoma Foundation for Peer Review:

Gary F. Gilbertson, MD, Tulsa (Position 13)

Jesse F. Richardson, MD, Stillwater (Position 14)

William O. Coleman, MD, Oklahoma City (Position 16)

Edward W. Allensworth, MD, Vinita (Position 17)

William L. Corporon, MD, Duncan (Position 18)

The board also nominated James R. Rhymer, MD, Clinton, for Doctor Leebron's vacant position, #3.

Mr. Bickham, Executive Director, explained that the Board of Medical Examiners has two vacancies, and the OSMA is responsible for submitting three names for each position to the governor for his consideration. The following were nominated:

Charles R. Gibson, MD, Chickasha

Richard J. Boatsman, MD, Lawton

James R. Rhymer, MD, Clinton

James V. Miller, MD, Ardmore

Roland M. Floyd, MD, Lawton

John M. Huser, MD, Weatherford

Mr Bickham presented his Executive Director's Report to the board, which included the following items:

A. A complaint has been filed with the Assistant US Attorney concerning advertising chelation therapy.

B. The Federal District Court dismissed the AMA's lawsuit against the US Department of Health and Human Services, challenging the constitutionality of Medicare provisions in the Deficit Reduction Act. The AMA has to decide upon what action now to take.

C. A letter has been received from the AMA regarding ethics of the "gatekeeper" concept. The AMA Judicial Council has stated that there is no violation of ethics under certain circumstances.

D. Mr Bickham reported that HCFA was interested in receiving a Medicare reimbursement demonstration project from Oklahoma. He noted that the association has attempted for a number of years to secure a more equitable reimbursement for Oklahoma physicians. He referred the trustees to Resolution 19, which addresses this issue.

E. The board moved to formally adopt the position of the Tulsa County Medical Society on the Administration's recommendation on a continuation of the physician fee freeze (opposition to the extension of the fee freeze).

F. The board recommended the transfer of \$500,000 to PLICO conditioned upon PLICO's willingness to rebate the interest income to OSMA. The transfer is to enhance the capitalization of PLICO.

G. The board agreed to hear the insurance appeal of Dr Lawrence Reed.

H. The board heard an informational report on the use of arbitration as a method for resolving professional liability disputes.

I. The board approved May 7-10 as the dates for the 1986 Annual Meeting at the Excelsior Hotel in Tulsa, Oklahoma.

J. The board voted to hold the 1987 Annual Meeting at Shangri-La resort in Afton, Oklahoma.

Late resolutions 16 through 21 were approved for consideration by the House. Three memorial resolutions were also approved and will be forwarded to the House: Mrs Dee Hampton, Dr William M. Leebron, and Mr Bill McCabe.

Dr John A. McIntyre presented a report on OMPAC. The OMPAC Report to the House is included under Reference Committee III.

The board reappointed Dr Mark R. Johnson as Editor-in-Chief of the OSMA JOURNAL.

The board then re-elected by acclamation Dr Michael J. Haugh as Chairman of the Board, and Dr Kenneth W. Whittington as Vice Chairman.

The following Special Membership Applications were submitted and approved by the board:

Undue Hardship:

Manoo G. Bhakta, MD, Clinton

Life Membership:

George S. Bozalis, MD, Oklahoma City

W. Turner Bynum, MD, Oklahoma City

Jon Chenette, MD, Okmulgee

Hugh M. Conner, Jr., MD, Oklahoma City

Charles S. Cunningham, MD, Poteau

John R. Danstrom, MD, Oklahoma City

Robert R. Dugan, MD, Oklahoma City

Louis S. Frank, MD, Oklahoma City

James L. Green, Jr., MD, Muskogee



Raymond F. Hain, MD, Oklahoma City  
Muriel E. Hyroop, MD, Oklahoma City  
Robert W. Kahn, MD, Oklahoma City  
Claude B. Knight, MD, Wewoka  
Willis E. Lemon, MD, Oklahoma City  
Chester W. Mengel, MD, Muskogee  
Earl I. Mulmed, MD, Tulsa  
Renee W. Papper, MD, Oklahoma City  
Paul T. Powell, MD, Ponca City  
William B. Renfrow, MD, Oklahoma City  
Helen Hughes Schmidt, MD, Oklahoma City  
Gerald M. Steelman, MD, Stillwater

Resolutions #17 and #18 were formally endorsed by the board for submission to the House of Delegates.

There being no further business, the board adjourned at 4:05 pm.

Respectfully submitted,  
Michael J. Haugh, MD  
Chairman of the Board

## **Report of the SECRETARY-TREASURER**

Subject: **Annual Report**

Presented by: Raymond L. Cornelison, Jr., MD, Secretary-Treasurer

Referred to: Reference Committee I

### **Introduction**

The financial information in your handbook includes:

- A. The Price-Waterhouse year-end audit (January 1 through December, 1984);
- B. The Budget and Audit Committee's review of the auditor's report.
- C. Balance Sheets and Income/Expense Statements for the First Quarter of 1985;
- D. A proposed budget for 1985; and
- E. Report A of the Board of Trustees — an update on Penn Square Bank liquidation.

### **Annual Audit**

The Annual Audit of our accountants, Price-Waterhouse, lists assets of \$5.8 million, compared with \$4.5 million in 1983. The increase reflects the recovery of monies previously held for Lloyd's of London, Hartford and other insurers under a reinsurance treaty negotiated in 1976. Current assets are almost \$2 million, while current liabilities are only \$1 million; thus, the association is in excellent financial condition.

As the shareholder of PLICO, OSMA has an equity of over \$3 million in that corporation. At the present time OSMA has a little over \$1 million in surplus, of which \$500,000 is pledged to PLICO for additional capital.

### **Revenue**

Last year the association received \$953,275 in income, and after adjustments for losses by the JOURNAL and the annual meeting, retained an excess of \$96,102 over expenses. Much of the surplus is attributable to interest income on the money released from the Lloyd's contract.

### **Expenses**

The cost of conducting OSMA business rose slightly in 1984. With few exceptions most expenses were at or below budget estimates. Insurance, utilities and maintenance were higher than projected, which is consistent with most business operations. Out-of-state travel and depreciation were also higher, reflecting the increase in the size of the OSMA Delegation to the AMA and the first-year write off of the computer depreciation. New expenses not budgeted were the cost of employing a director for the Physicians Recovery Program, continuation of the AMA-GTE communications system, and the employment of a contract lobbyist for the Council on State Legislation.

Overall the income and expense sections of the audit reflect a growing and viable organization that is in good financial condition. There were some auditing changes made in the presentation of council expenses, but all were within budget projections except the Council on State Legislation. A new contract employee was hired in August to handle OSMA state lobbying activities, and the cost is included in council expenses.

### **Budget and Audit Report**

The committee reviews the accountant's report to determine if income/expenditures are consistent with OSMA policy and conform to accounting principles acceptable to the membership. The report will be presented at the Opening Session of the House of Delegates.

### **First Quarter Financial Report**

The January through March Financial Report will be presented at the annual meeting.

### **1985 Budget**

The budget presented for 1985 anticipates income of \$1.2 million (gross income before adjustments) and expenditures of \$1.3 million — anticipating a deficit of approximately \$100,000. The Board of Trustees authorized the Council on Professional and Public Relations (see report in Reference Committee II) to prepare a filmed documentary that would explain to the public the problems created by third-party intrusions in the physician/patient relationship. The project is expected to cost about \$90,000, and will result in 1-, 5-, 15-, and 30-minute presentations. The association has set aside in previous years \$35,000 for such an educational campaign.

The budget also anticipates House of Delegates approval of the continuation of the Physician Recovery Program — a new activity which now has a medical director (see report in Reference Committee III). The recommended budget for 1985 is \$30,000, but a portion of that is to be funded by the Oklahoma Osteopathic Association, who wants to participate in the program. Should the cooperative effort be approved by the House of Delegates and the Board of Trustees, we anticipate their contribution will approximate \$10,000.

The budgets for the Council on State Legislation and the Council on Governmental Activities include the cost of contract employees. The expenses for Student, Resident and Auxiliary activities have been more clearly identified in the budget. There have been administrative expenses and salary adjustments to offset expected increases.

## Summary

The budget is based on the following assumptions:

1. That OSMA membership will continue to grow as it has in previous years, and that unified membership will be maintained;
2. That a return of 8-10% can be earned on the OSMA surplus;
3. That existing contracts with OFPR, PLICO and the Oklahoma County Medical Society will continue;
4. That the House of Delegates nor the Board of Trustees will take actions that significantly alter income and expense.

The budget is a realistic expectation of the cost of continuing the association's activities.

Respectfully submitted,  
Raymond L. Cornelison, Jr., MD

**Oklahoma State Medical Association  
Financial Statements  
\* \* \* \* \***

December 31, 1984 and 1983

Colcord Building  
15 North Robinson  
Oklahoma City, Oklahoma 73102  
405 272-9251

March 7, 1985

House of Delegates  
Oklahoma State Medical Association  
Oklahoma City, Oklahoma

We have examined the balance sheet of Oklahoma State Medical Association ("Association") as of December 31, 1984 and 1983 and the related statements of revenues and expenses, of changes in unappropriated fund balance and of changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We did not examine the financial statements of Physicians Liability Insurance Company ("Company"), a wholly-owned unconsolidated subsidiary accounted for on the equity method of accounting. The investment in the Company represents 53% and 68% of total assets of the Association for the years ended December 31, 1984 and 1983, respectively, and 88% of the net loss in 1983; for the year ended December 31, 1984, the Association recorded a loss of \$509,055 on its investment in the Company. The financial statements of the Company were examined by other independent accountants whose report dated March 8, 1985 expressed an unqualified opinion on those statements, and our opinion expressed herein, insofar as it relates to the amounts included for the Company, is based solely upon the report of the other accountants.

The Association does not provide for depreciation on buildings estimated to approximate \$15,000 for 1984 and 1983 as required by generally accepted accounting principles.

In our opinion, except for not providing for depreciation as described in the preceding paragraph and based upon the report of other independent accountants referred to above, the financial statements referred to above present fairly the financial position of Oklahoma State Medical Association as of December 31, 1984 and 1983, the results of its operations and the changes in its financial position for the years then ended in conformity with generally accepted accounting principles applied on a consistent basis.

Our examinations were made for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplemental schedules are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the examinations of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Price Waterhouse

## Balance Sheet Assets

	December 31,	
	1984	1983
<b>Current assets:</b>		
Cash	\$ 9,354	\$ 8,195
Savings accounts and certificates of deposit	953,568	217,981
Accounts receivable:		
Dues	644,733	609,896
Reinsurance companies (Note 11)	370,000	—
Prepaid expenses	5,033	4,717
<b>Total current assets</b>	<b>1,982,688</b>	<b>840,789</b>
<b>Property and equipment, partially pledged to secure long-term debt (Note 4):</b>		
Land	7,808	7,808
Building	379,515	379,515
Pavement	2,451	2,451
Furniture, fixtures and equipment	419,354	156,442
Equipment under capital lease	15,330	25,650
	824,458	571,866
<b>Less: Accumulated depreciation</b>	<b>(161,240)</b>	<b>(114,000)</b>
	<b>663,218</b>	<b>457,866</b>
<b>Equity in unconsolidated subsidiary (Note 10)</b>	<b>3,096,169</b>	<b>3,105,224</b>
<b>Other assets:</b>		
Due from Federal Deposit Insurance Corporation, net of allowance of \$211,401 (Note 2)	72,196	137,614
Loan acquisition costs, net of amortization	4,282,472	—
Organization expense, subsidiary, net of amortization	—	23,940
Deposits	—	1,983
	76,478	168,258
	<b>\$5,818,553</b>	<b>\$4,572,137</b>

The accompanying notes are an integral part of these financial statements.

## Liabilities and Fund Balances

	December 31,	
	1984	1983
<b>Current liabilities:</b>		
Current portion of long-term debt	\$ 6,205	\$ 10,292
Accounts payable (Note 3)	439,257	254,639
Loans and scholarships payable	100	100
<b>Accrued liabilities:</b>		
Retirement plan (Note 5)	1,900	(650)
Deferred income (Note 6)	641,550	658,660
<b>Total current liabilities</b>	<b>1,089,012</b>	<b>923,041</b>
<b>Long-term debt (Note 4)</b>	<b>142,012</b>	<b>134,126</b>
<b>Commitments and related party transactions (Notes 7, 8 and 11)</b>	<b>—</b>	<b>—</b>
<b>Fund balances:</b>		
Appropriated for public education	35,619	35,619
Appropriated for building maintenance	30,217	30,217
Unappropriated	4,521,693	3,449,134
	4,587,529	3,514,970
	<b>\$5,818,553</b>	<b>\$4,572,137</b>

The accompanying notes are an integral part of these financial statements.



# Statement of Revenues and Expenses

	Years ended December 31,	
	1984	1983
From operations:		
Revenue	\$ 953,275	\$681,798
Expenses	742,181	617,482
Excess of revenue over expenses from operations	211,094	64,316
JOURNAL:		
Revenue	87,398	89,432
Expenses	156,330	137,814
Excess of expenses over revenue from JOURNAL	(68,932)	(48,382)
Annual meeting:		
Revenue	42,756	31,556
Expenses	88,816	105,904
Excess of expenses over revenue from annual meeting	(46,060)	(74,348)
Excess (deficiency) of revenues over expenses before other revenue (expenses) and extraordinary items	96,102	(58,414)
Other revenue (expenses):		
Special assessment	—	13,539
Loss from unconsolidated subsidiary (Note 10)	(509,055)	(481,878)
Amortization of organization expense, subsidiary	(23,940)	(23,940)
	(532,995)	(492,279)
Excess of expenses over revenues before extraordinary items	(436,893)	(550,693)
Extraordinary items (Note 11)	1,509,452	—
Excess (deficiency) of revenues over expenses	\$1,072,559	(\$550,693)

The accompanying notes are an integral part of these financial statements.

## Statement of Changes in Unappropriated Fund Balance

	Years ended December 13,	
	1984	1983
Balance, beginning	\$3,449,134	\$3,999,827
Excess (deficiency) of revenues over expenses	1,072,559	(550,693)
Balance, ending	\$4,521,693	\$3,449,134

The accompanying notes are an integral part of these financial statements.

# Statement of Changes in Financial Position

	Years ended December 31,	
	1984	1983
Working capital provided:		
From operations:		
Excess (deficiency) of revenues over expenses	\$1,072,559	(\$550,693)
Expenses not affecting working capital during the current period -		
Equity in loss of subsidiary	509,055	481,878
Depreciation and amortization	71,614	41,095
Total from operations	1,653,228	(27,720)
Decrease in due from Federal Deposit Insurance Corporation	65,418	73,788
Decrease in deposits	1,983	—
Increase in long-term debt	7,886	—
Total working capital provided	1,728,515	46,068
Working capital used:		
Purchase of property and equipment	252,587	21,098
Investment in subsidiary	500,000	—
Decrease in long-term debt	—	8,986
Total working capital used	752,587	30,084
Increase in working capital	\$ 975,928	\$ 15,984

## Changes in Components of Working Capital

Increase (decrease) in current assets:		
Cash	\$ 1,159	(\$ 16,002)
Savings accounts and certificates of deposit	735,587	123,740
Accounts receivable	404,837	(23,237)
Prepaid expenses	316	(1,501)
	1,141,899	83,000
(Increase) decrease in current liabilities:		
Current portion of long-term debt	4,087	5,351
Accounts payable	(184,618)	(45,592)
Loans and scholarships payable	—	100
Accrued liabilities	(2,550)	13,850
Deferred income	17,110	(40,725)
	(165,971)	(67,016)
Increase in working capital	\$ 975,928	\$ 15,984

The accompanying notes are an integral part of these financial statements.

## Notes to Financial Statements

### Note 1 — Significant Accounting Policies

The following is a summary of certain significant accounting policies followed in the preparation of these financial statements. Except for the omission of depreciation on the building, these policies conform to generally accepted accounting principles:

**Property and equipment.** Property and equipment, including the capitalized leases, are recorded at cost. Depreciation of the property, except the building, is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years.

**Deferred income.** Deferred income is subsequent years' dues and annual meeting income collected in current year.

**Investment in subsidiary.** Investment in Physicians Liability Insurance Company (a wholly-owned subsidiary) is accounted for by the equity method. Under this method the Association's equity in the net earnings or losses of the subsidiary is included currently on the Association's statement of revenues and expenses. Any dividends received from the subsidiary will be reflected as a reduction of the investment.

**Loan acquisition costs.** Loan acquisition costs are amortized on a straight-line basis over the life of the loan.

**Organization expense - Subsidiary.** Organization expense is amortized on a straight-line basis over a five-year period.

**Organization.** The Association was organized as a nonprofit organization and, as such, is exempt from income taxes under Section 501(c)(6) of the Internal Revenue Code.

### Note 2 — Due from Federal Deposit Insurance Corporation

The Association had cash on deposit and certificates of deposit totaling \$679,187 in Penn Square Bank of Oklahoma City, Oklahoma in July, 1982 when the Bank was closed by the Federal Deposit Insurance Corporation (FDIC). Of this amount, \$243,071 was determined by the FDIC to be covered by its insurance and has been recovered by the Association. The remainder, however, is being reflected as a receivable from the FDIC.

and will be repaid only as the ultimate liquidation of the Bank's assets permit and only in the amounts available to other unsecured creditors on a pro rata basis. For financial purposes, this receivable was originally valued at approximately 50 percent of its face value.

**Note 3 — Accounts Payable**

The following is a summary of the accounts payable at December 31, 1984 and 1983:

	1984	1983
Trade	\$ 42,742	\$ 37,992
Physicians Liability Insurance Company	152,500	—
Dues	20,746	67,733
Leebron Memorial Fund	6,584	6,459
Medical education endowment	199,562	130,955
Other	17,123	11,500
	<u>\$439,257</u>	<u>\$254,639</u>

**Note 4 — Long-Term Debt**

The following is a summary of long-term debt at December 31, 1984 and 1983:

	1984	1983
Note payable to a company; secured by real estate; payable in 180 monthly payments of \$1,448 including interest at 10% and one payment of \$69,548 due in 1994	\$133,883	\$137,675
Capitalized leases; secured by certain equipment; payable in monthly payments of \$404 and \$582 including interest at 21% and 13%, respectively	14,334	6,743
	148,217	144,418
Less: Current portion	(6,205)	(10,292)
	<u>\$142,012</u>	<u>\$134,126</u>
Amounts due on long-term debt in future years as of December 31, 1984 are as follows:		
1986	\$ 7,113	
1987	8,174	
1988	9,422	
1989	9,231	
1990	6,890	
1991-1994 (Term)	101,182	
	<u>\$142,012</u>	

**Note 5 — Retirement Plan**

The Association has a defined benefit pension plan which covers employees who are twenty-four and one-half years of age or older and have at least six months of service. The plan has a fiscal year of June 1 to May 31. The total pension expense for 1984 and 1983 is \$26,406 and \$25,783, respectively. The amount of accrued pension expense for the year is funded by the Association in annual contributions to the pension plan. The actuarial present value of the accumulated benefits to participants of the plan and the net assets available for those benefits as of the beginning of the plan years 1984 and 1983 is as follows:

	1984	1983
Actuarial present value of the accumulated plan benefits:		
Vested	\$ 6,901	\$12,231
Nonvested	3,922	115
	<u>\$10,823</u>	<u>\$12,346</u>
Net assets available for benefits	<u>\$77,423</u>	<u>\$87,657</u>

In determining the actuarial present value of the accumulated plan benefits, an assumed weighted average rate of 7-8% was used.

**Note 6 — Deferred Income**

The following is a summary of deferred income at December 31, 1984 and 1983:

	1984	1983
Dues	\$636,300	\$652,910
Annual meeting	5,250	5,750
	<u>\$641,550</u>	<u>\$658,660</u>

**Note 7 — Commitments**

Long-term leases -

The following is a summary of the Association's lease obligations at December 31, 1984:

	1985	1986
Automobiles	<u>\$15,269</u>	<u>\$8,560</u>

**Note 8 — Related Party Transactions**

For the years ended December 31, 1984 and 1983, the Association had an agreement with Physicians Liability Insurance Company, a wholly-owned unconsolidated subsidiary, to provide loss prevention services for the insurance company. The Association incurred expenses totaling \$36,623 and \$30,206 for 1984 and 1983, respectively, and was reimbursed a total of \$100,000 each year by the subsidiary.

**Note 9 — Professional Liability Stabilization Program**

The Professional Liability Stabilization Program was established during the year ended May 31, 1976 by assessing the doctors a 15% surcharge on their basic professional liability policies. The Insurance Company of North America provided the basic \$100,000/\$300,000 policy. This money is under the control of two trustees, one appointed by the Association and one appointed by the insurer. As of December 31, 1984 the balance on deposit was \$471,477, which is not included in the financial statements. The funds will be used only if the insurer's reserves are exhausted through payment of claims.

**Note 10 — Equity in Unconsolidated Subsidiary**

The following is a condensed balance sheet and statement of operations for the unconsolidated subsidiary:

	December 31,	
	1984	1983
Assets:		
Cash	\$ 1,933,283	\$ 1,224,571
Investments	22,833,698	21,043,537
Other	861,987	384,013
	<u>\$25,628,968</u>	<u>\$22,652,121</u>
Liabilities and stockholders' equity:		
Unearned premiums	\$ 1,258,854	\$ 1,576,121
Losses and loss adjustment expense	19,623,374	16,510,751
Other	1,650,571	1,460,025
Total stockholders' equity	3,096,169	3,105,224
	<u>\$25,628,968</u>	<u>\$22,652,121</u>
	December 31,	
	1984	1983
Revenue:		
Premiums earned	\$17,741,913	\$13,923,861
Investment income	2,833,591	2,207,552
	<u>20,575,504</u>	<u>16,131,413</u>
Expenses:		
Losses	15,025,289	13,782,634
Loss adjustment	2,999,092	437,288
Other operations	3,060,178	2,435,369
Income taxes	—	(42,000)
	<u>21,084,559</u>	<u>16,613,291</u>
Net loss	<u>(\$ 509,055)</u>	<u>(\$ 481,878)</u>

The subsidiary is not consolidated due to the diversity of operations and lack of management control.

**Note 11 — Extraordinary Items**

In 1984, the Association settled a previous insurance plan (1977) whereby Hartford Insurance Company and Lloyd's of London provided an excess liability insurance coverage policy for insured doctors in the state of Oklahoma. As part of the agreement, the original premiums were placed in a trust account under the administration of the Oklahoma State Medical Association and at the termination of the coverage, any funds plus interest not used to pay claims and expenses would be returned to the Association.

It was determined in 1984 that the statute had expired for filing claims (with minor exceptions) against this policy year and the funds became unrestricted and available for the general benefit or assignment of the Association. After settlement of all claims and expenses with Hartford and Lloyd's, the Association realized a gain on the transaction of \$1,509,452 which has been recorded as an extraordinary item.

As part of the agreement releasing the funds, the Association agreed to assume the risks for any future claims that might arise from the 1977 policy year up to \$1,000,000. In exchange for an agreement to provide a capital contribution of \$1,000,000 from the Association, the Physicians Liability Insurance Company (see Note 10) agreed to assume this risk in place of the Association. As of December 31, 1984, \$500,000 of this contribution to capital has been made.



# Supplemental Schedules

## Schedule of Revenues

	Years ended December 31,	
	1984	1983
From operations:		
Membership dues	\$629,636	\$587,444
Interest and other	187,652	36,922
Building lease	33,205	31,440
Membership directory	12,348	20,766
Computer	90,434	5,226
Total revenue from operations	<u>\$953,275</u>	<u>\$681,798</u>
From JOURNAL:		
Subscriptions allocated from dues	\$ 31,302	\$ 31,610
Advertising and sales	56,096	57,822
Total revenue from JOURNAL	<u>\$ 87,398</u>	<u>\$ 89,432</u>
From annual meeting:		
Exhibit fees	\$ 22,235	\$ 9,750
Contributions	450	2,300
Ticket sales	20,071	19,401
Class reunion	—	105
Total revenue from annual meeting	<u>\$ 42,756</u>	<u>\$ 31,556</u>

## Schedule of Expenses

	Years ended December 31,	
	1984	1983
General membership expenses:		
Salaries	\$301,921	\$281,050
Awards	1,606	1,650
Councils	92,383	78,942
Data processing	14,326	1,903
Depreciation and amortization	47,679	16,716
Dues and subscriptions	4,516	2,995
Equipment rental and expense	33,772	33,085
In-state travel	3,118	2,845
Insurance	44,913	36,039
Interest	16,403	14,879
Legal and professional	10,850	16,700
Loss prevention project	36,623	30,206
Membership directory	—	18,585
Office supplies	15,922	17,028
OSMA newsletter	9,868	6,764
Out-of-state travel and AMA convention expense	91,957	64,633
Payroll taxes	22,761	21,230
Pension costs	26,406	25,783
Physicians recovery program	8,876	—
Postage and shipping	30,215	27,915
Repairs and maintenance	10,035	4,512
Services	3,632	3,574
Staff and officers' expense	25,269	23,051
Telephone and utilities	40,824	26,586
Other general expense	9,587	8,826
Total before allocation of overhead	903,462	765,497
Expense reimbursement from subsidiary	(100,000)	(100,000)
Overhead allocated to JOURNAL	(29,530)	(18,833)
Overhead allocated to annual meeting	(31,751)	(29,182)
Total general membership expenses	<u>\$742,181</u>	<u>\$617,482</u>

## Council expenses:

State governmental activities	\$ 31,836	\$ 19,273
Federal governmental activities	23,008	25,016
Medical education	1,228	361
Medical services	(1,434)	381
Member services	8,910	5,535
Planning and development	8,763	7,505
Professional and public relations	19,180	20,862
Public and mental health	—	9
Hospital medical staffs	892	—
Total council expenses	<u>\$ 92,383</u>	<u>\$78,942</u>

## JOURNAL expenses:

Salaries	\$ 36,000	\$ 36,000
Advertising	13,362	13,517
Artwork	4,792	3,519
Printing	59,437	59,282
Proofreading	895	793
Supplies and other	12,314	5,870
Total before allocation of overhead	126,800	118,981

## Overhead allocated from general membership expenses

	29,530	18,833
Total JOURNAL expenses	<u>\$156,330</u>	<u>\$137,814</u>

## Annual meeting expenses:

Exhibit expense	\$ 2,705	\$ 1,212
Travel	619	468
Special events	—	3,419
Planning	—	1,515
Printing	7,055	7,855
Speaker	5,026	3,888
Entertainment	4,827	4,017
Luncheon	188	348
Signs and security	773	1,478
Audio visual equipment	1,023	4,006
Sports activities	40	131
Hotel	31,522	42,215
Ladies activities	—	4,381
Other	3,287	1,789
Total before allocation of overhead	57,065	76,722

## Overhead allocated from general membership expenses

	31,751	29,182
	<u>\$ 88,816</u>	<u>\$105,904</u>



Ready for the inaugural gala are Mary Ann Deen, OSMA Auxiliary president for 1985-86, and her husband, Gordon. The Deens are from Ada.

**Balance Sheet**  
**March 31, 1985**

<b>Current Assets</b>	
Cash	\$ 1,582
Savings accounts and certificates of deposit	1,377,370
Accounts receivable	126,240
Accounts receivable — Insurance premium refund	370,000
Prepaid expenses	8,996
<b>Total Current Assets</b>	<b>1,884,188</b>
<b>Property and Equipment</b>	
Land	7,808
Building	379,515
Pavement	2,451
Furniture, fixtures and equipment	171,716
Electronic data processing	215,451
Equipment under capital lease	15,330
	792,271
Less: Accumulated depreciation and amortization	132,198
	660,073

<b>Investment in Subsidiary</b>	3,096,169
---------------------------------	-----------

<b>Other Assets</b>	
Loan acquisition costs — net of amortization	4,172
Accounts receivable — FDIC	72,196
	76,368
<b>Total</b>	<b>\$5,716,798</b>

**Liabilities and Fund Balances**

<b>Current Liabilities</b>	
Current portion of long-term liabilities	\$ 6,205
Accounts payable	458,154
JOURNAL award fund	100
Loan and scholarships payable	9,036
Retirement expense	1,900
Deferred income	482,475
<b>Total Current Liabilities</b>	<b>957,870</b>

<b>Long-Term Liabilities</b>	
Notes payable	147,208
Less: Current portion included above	6,205
	141,003

<b>Fund Balances</b>	
Appropriated for public education	35,619
Appropriated for building maintenance	30,217
Unappropriated	4,552,089
	4,617,925
<b>Total</b>	<b>\$5,716,798</b>

**Statement of Changes in Fund Balances**  
**for the Months Ended March 31, 1985**

<b>Appropriated for Public Education</b>	
Beginning of period	\$ 35,619
Contribution from Central Oklahoma Council of Medical Staffs	—
End of period	35,619
<b>Appropriated for Building Maintenance</b>	
Beginning of period	30,217
Appropriation for period	—
End of period	30,217
<b>Unappropriated</b>	
Beginning of period	4,521,693
Excess of revenue over expenses	30,396
End of period	4,552,089
<b>Total</b>	<b>\$4,617,925</b>

**Statement of Revenues and Expenses**  
**for the Months Ended March 31, 1985**

<b>From Operations</b>	
Revenue	\$220,054
Expenses	221,245
<b>Excess of Expenses Over Revenue</b>	
From Operations	(1,191)
<b>JOURNAL</b>	
Revenue	26,897
Expenses	22,238
<b>Excess of Revenue Over Expenses</b>	
From JOURNAL	4,659
<b>Annual Meeting</b>	
Revenue	12,690
Expenses	2,179
<b>Excess of Revenue Over Expenses</b>	
From Annual Meeting	10,511
<b>Other Revenue (Expenses)</b>	
Excess of reimbursement over expense for subsidiary	16,417
<b>Net Excess of Revenues Over Expenses</b>	<b>\$ 30,396</b>

**Schedule of Revenues**  
**for the Months Ended March 31, 1985**

<b>From Operations</b>	
Membership dues	\$151,575
Interest	5,035
Commissions	19,645
Building lease	7,200
Membership directory sales and advertising	2,055
Computer	31,264
Special Olympics	3,280
<b>Total Revenue from Operations</b>	<b>220,054</b>
<b>From JOURNAL</b>	
Subscription	7,695
Advertising	19,202
<b>Total Revenue from JOURNAL</b>	<b>26,897</b>
<b>From Annual Meeting</b>	
Exhibit fees	11,500
Contributions	500
Ticket sales	615
Short courses	75
<b>Total Revenue from Annual Meeting</b>	<b>\$ 12,690</b>



At the inaugural ball, Dr James B. Eskridge III beams with delight at the plaque of appreciation he has received for his leadership as OSMA President 1984-85.



**Schedule of Expenses**  
for the Months Ended March 31, 1985

**Proposed Budget**  
1985

**General Membership Expenses**

Salaries	\$ 78,447
Trustee fee	740
Awards	335
*Councils	37,128
Depreciation and amortization of leased equipment	5,046
Dues and subscriptions	490
Equipment rental	8,784
Insurance	5,720
In-state travel	265
Interest	3,335
Legal and professional	300
Office supplies	6,376
Out-of-state travel and AMA convention	16,328
Payroll taxes	7,014
Postage and shipping	11,996
Repairs and maintenance	1,680
Services	682
Staff and officers	16,717
Telephone and utilities	8,369
Other general expense	2,878
Newsletter	3,471
Computer maintenance contract	3,849
Computer supplies	1,295
Total before allocation of overhead	221,245
Excess of reimbursement over expense for subsidiary	(16,417)
Total General Membership Expenses	<u>204,828</u>

**Council Expenses**

Governmental activities	7,700
State legislation	15,849
Professional and public relations	6,338
Planning and development	2,680
Medical education	391
Medical services	(9,051)
Member services	4,671
Physician's recovery program	8,550
Total Council Expenses*	<u>\$ 37,128</u>

**JOURNAL Expenses**

Salaries	\$ 9,000
Printing	8,265
Advertising	2,390
Art work	1,344
Proofreading	135
Supplies	104
Operating	1,000
Total JOURNAL Expenses	<u>22,238</u>

**Annual Meeting Expenses**

Exhibit	92
Planning	58
Printing	445
Miscellaneous supplies	1,012
Speakers	500
Lunches & reception	72
Total Annual Meeting Expenses	<u>\$ 2,179</u>

**Membership Income**

Dues	\$650,000
Interest and commissions	125,000
Building lease	33,000
Membership directory	25,000
Computer contract	<u>115,000</u>

\$ 948,000

**JOURNAL Income**

Subscriptions	32,000
Advertising and sales	<u>57,000</u>

89,000

**Annual Meeting Income**

Exhibit fees	25,000
Ticket sales	24,500

49,500

**Underwriting and Risk Management Income**

	100,000
Total Income	<u>100,000</u>

100,000

\$1,186,500

Projected Total Income

\$1,186,500

Projected Total Expenses

1,285,223

(\$ 98,723)

**Membership Expenses**

Salaries	\$322,500
Awards	1,500
*Councils	236,800
Data Processing	2,000
Depreciation & amortization	48,000
Dues & subscriptions	4,500
Equipment & rental	34,000
In-state travel	3,500
Insurance	45,000
Interest	15,000
Legal & professional	12,000
Loss prevention project	36,623
Membership directory	20,000
Office supplies	16,000
Computer maintenance	13,800
Travel & AMA convention expense	88,000
Payroll taxes	23,000
Pension cost	26,000
Physician recovery program	20,000
Postage & shipping	35,000
Repairs & maintenance	6,000
Services	3,500
Staff & officers	25,000
Telephone & utilities	40,000
Other general expense	<u>2,000</u>

1,079,723

**Council Expenses**

State legislation	51,000
Governmental activities	32,000
Medical education	2,000
Medical services	3,000
Members services	3,000
Planning & development	5,000
Professional & public relations	122,800
Public & mental health	1,500
Hospital medical staffs	2,000
Medical student activities	8,000
Resident activities	2,500
Auxiliary activities	<u>4,000</u>

\*(included in above expenses)

236,800

**JOURNAL Expenses**

156,000

**Annual Meeting Expenses**

49,500

**TOTAL EXPENSES**

\$1,285,223

# Council Expenses

	Proposed Yearly Budget 1985	Yearly Budget 1984	Yearly Audit Actual 1984	Over/Under Budget 1984
Council on State Legislation	\$ 51,000	\$15,700	\$ 31,836	\$16,136 over
Council on Gov. Activities	32,000	13,500	23,008	9,508 over
Council on Prof. & Public Rel.	122,800	25,000	19,180	5,820 under
Council on Medical Education	2,000	2,000	1,228	772 under
Council on Medical Services	3,000	1,500	(1,434)	2,934 under
Council on Member Services	3,000	1,500	8,910	7,410 over
Council on Pub. & Mental Health	1,500	2,250	-0-	2,250 under
Council on Planning & Dev.	5,000	5,100	8,763	3,663 over
Council on Hospital Med. Staffs	2,000	2,000	892	1,108 under
Physician's Recovery Program	20,000	-0-	8,876	8,876 over
		\$68,550	\$101,259	\$32,709 over
Medical Student Activity	8,000			
Resident Activities	2,500			
Auxiliary	4,000			
	\$256,800			

\* On the OSMA Proposed Budget for 1985, Physician's Recovery Program is listed under membership expenses instead of council expenses, thus the above proposed budget figure is \$20,000 more than the proposed budget figure of \$236,800.

# Council Expenses 1984

**Council on State Legislation:** over \$16,136  
1984 yearly audit figures include salary, 1984 budget figures did not.

**Council on Governmental Activities:** over \$9,508  
1984 yearly audit figures include salary, 1984 budget figures did not.

**Council on Professional & Public Relations:** under \$5,820  
1984 budget figures for this council included cost of the OSMA Newsletter but it was accounted for separately on OSMA books. Cost for the Newsletter was \$9,868, so this council is actually \$4,048 over budget.

**Council on Medical Education:** under \$772  
Council did not use amount budgeted.

**Council on Medical Services:** under \$2,934  
Receipts for the sale of the new guide book for permanent impairment have been credited to this account, so instead of spending money, this council has made enough over what they spent to show a credit.

**Council on Member Services:** over \$7,410  
Expenses for seminars had been paid at the end of 1984 but receipts for seminars came in in 1985.

**Council on Public & Mental Health:** under \$2,250  
Council did not use amount budgeted.

**Council on Planning & Development:** over \$3,663  
Large expenditures that put this council over budget were \$3,498 to Fountainhead Lodge in April and \$3,095 to the Sheraton Inn in November.

**Council on Hospital Medical Staffs:** under \$1,108  
Council did not use amount budgeted.

**Physician's Recovery Program:** over \$8,876  
1984 budget did not include this expense.

# Report of the COMMITTEE ON APPROPRIATIONS AND AUDITING

## Subject: Annual Report

Presented by: Raymond L. Cornelison, Jr., MD, Chairman  
Secretary-Treasurer

Referred to: Reference Committee I

## Audit

The Committee reviewed the audit report of Price-Waterhouse and feels the accounting conforms to standards acceptable to the Association. The Committee does feel the Employee Retirement Plan needs a thorough review.

## Budget

The Budget for 1985 was thoroughly reviewed, and the Committee was impressed with the magnitude of the program and projects conducted by OSMA. All are obviously important and designed to improve and enhance the image of the Association and its members, and to improve the quality of medical care delivered in Oklahoma. However, it is the firm conviction of your Committee that the Association should not resort to deficit financing or spend its reserves to finance OSMA operation. We are convinced that Association members will respond to positive programs developed by the leadership and will pay the fare necessary to finance them. For special one-time projects we would recommend a special assessment.

## Recommendations

1. That a thorough review of the OSMA Employees Retirement Plan be conducted and a subsequent report be made to the Board of Trustees; and
2. That if expenditures cannot be reduced to match income, then a special one-time assessment be levied.

Raymond L. Cornelison, Jr., MD, Chairman  
Kent Braden, MD  
Gerald W. McCullough, MD  
Robert O. Raulston, MD  
Lanny F. Trotter, MD  
Kenneth W. Whittington, MD



# Oklahoma State Medical Association

## BOARD OF TRUSTEES

### Report A

Subject: **Penn Square Bank**

Presented by: Raymond L. Cornelison, Jr., MD  
Secretary-Treasurer

Referred to: Reference Committee I

#### Introduction

At the time of the Penn Square Bank failure (July 5, 1982), the association had on deposit, in several accounts and in Certificates of Deposit \$688,302.12. Through negotiation with the FDIC \$256,384.11 was withdrawn, leaving a balance of \$431,918.01. On March 24, 1983 the FDIC paid the association \$73,787.72. On August 21, 1984 the FDIC paid the association \$65,417.38. The bank still owes OSMA \$292,712.91.

We have been advised by the FDIC that another disbursement will likely be made this year (no date has been set).

For accounting purposes, one-half of the balance has been written off the association books, and the 1985 budget does not anticipate recovery.

This is an informational report.

Membership Report April 18, 1985		
	1984	1985
Regular Membership	3,073	3,139
Junior Members (Residents & Students)	378	406
Life Members	300	323
Affiliate Members	6	12
Hardship Members	4	2
Total Number of Members	3,761	3,882
Pending Members	250	200
	4,011	4,082
Non-Members	483	480

## Report of the COUNCIL ON LONG-RANGE PLANNING AND DEVELOPMENT

Subject: **Annual Report**

Presented by: George H. Kamp, MD, Chairman

Referred to: Reference Committee I

#### Introduction

The Council on Planning and Development will study and make recommendations to the Board of Trustees and to the House of Delegates concerning the long-range objectives of the association, and will assess and make recommendations regarding the resources and programs necessary to reach those objectives.

#### Review of Activities

The meeting schedule for the Council on Planning and development is to have two meetings annually, one in the fall basically to review the progress of the various councils and their annual programs which were adopted at the preceding House of Delegates meeting, and in the spring to review reports and resolutions that are to be submitted to the upcoming House of Delegates. In both sessions the council attempts to look at long-range goals and objectives of the OSMA and to plan strategy on how to attain goals and objectives which have been set.

During the fall meeting, and for the first time in many years, the Council on Planning and Development meeting was dedicated to long-range planning. Mr Norman Losh, President, Medical Development Corporation, Littleton, Colorado, was the guest speaker/instructor. Mr Losh presented detailed information on the subjects of the future role and philosophy of the Oklahoma State Medical Association, current trends and issues in health care, marketing in health care, convenience medicine, and medical staff relationships with hospital trustees and administrators.

During a later session of the council meeting, the process known as the Nominal Group Technique was used to identify critical issues for the OSMA to direct its attention for the future. Some thirty issues were initially suggested, and by using the nominal group technique, the top five issues in order of priority were identified, and are as follows:

- (1) Governmental intrusion and intrusion by other third parties in the physician/patient relationship.
- (2) Need for an OSMA public information program.
- (3) Physician oversupply and maldistribution.
- (4) Malpractice
- (5) More and better explanation of alternate health care delivery systems.

During the spring session of the Council on Planning and Development, it was agreed that these five major issues should be a part of the 1985-86 program of the appropriate councils under which they would fall.

#### Council Activities

The Council on State Legislation proposes a continued program of monitoring health legislation at the State Capitol.

Budget Request \$51,000

The Council on Governmental Activities plans to continue its federal legislative activities.

Budget Request \$32,000

The Council on Professional and Public Relations plans to expand its current activities, mainly with the production of a PR film.

Budget Request \$124,800

The Council on Medical Education will continue its CME accreditation and certification program, and continue to assist the State Regents for Higher Education in a study of physician manpower.

Budget Request \$2,000

The Council on Medical Services will continue its activities of peer review and socioeconomic issues of medicine.

Budget Request \$3,000

The Council on Member Services supports and promotes a wide range of direct benefits for members of the association.

Budget Request \$3,000

The Council on Public and Mental Health will continue its programs of monitoring vital public and mental health issues of our state, particularly prenatal, maternal and child health.

Budget Request \$1,500

The Council on Hospital Medical Staffs will continue and try to expand its network of physicians throughout the state.

Budget Request \$2,000

The Council on Planning and Development

Budget Request 5,000

TOTAL COUNCIL REQUESTS \$218,300

This is an informational report.

Respectfully submitted,  
George H. Kamp, MD, Chairman  
J. B. Eskridge, III, MD  
Elvin M. Amen, MD  
John R. Alexander, MD  
Raymond L. Cornelison, Jr., MD  
Larry L. Long, MD  
Robert G. Perryman, MD  
Michael J. Haugh, MD  
Kenneth W. Whittington, MD  
William O. Coleman, MD  
John A. Blaschke, MD  
M. Joe Crothwait, MD  
Perry A. Lambird, MD  
William R. Smith, MD  
George W. Prothro, MD  
William L. Hughes, MD  
Orange M. Welborn, MD  
Ed L. Calhoon, MD  
Floyd F. Miller, MD  
Victor L. Robards, Jr., MD  
Arnold G. Nelson, MD  
John A. McIntyre, MD  
James B. Pitts, Jr., MD

## Report of the CONSTITUTION AND BYLAWS COMMITTEE

Subject: Annual Report  
Presented by: Floyd Miller, MD, Chairman  
Referred to: Reference Committee I

### Introduction

The Constitution and Bylaws Committee is charged with the responsibility of considering all proposed amendments to the Association's Constitution and Bylaws to assure that they are in appropriate form and, if adopted, do not cause conflicts with other portions of the two documents. The Committee may originate proposed amendments, or consider amendments proposed by component

societies or individual members of the Association and shall then present them with its recommendations to the House of Delegates for consideration.

The Committee has considered three sets of proposed amendments to be considered by this House of Delegates. The first set was created by an action taken in the 1984 House of Delegates, the second set was created by the Committee itself and takes the form of several house cleaning amendments, while the third set, regarding the creation of special House of Delegates sections, came out of an action taken by the Association's Council on Planning and Development.

Each of these proposed amendments shall be handled separately and shall be followed by a recommendation from the Constitution and Bylaws Committee.

### Physician Recovery Committee

During the 1984 Annual Meeting of the OSMA House of Delegates, a special report from the Physician Committee was adopted calling for the creation of a Physician Recovery Committee. The following suggested bylaws amendments would accomplish the conversion of the Physician Committee over to the Physician Recovery Committee.

Chapter X of the OSMA Bylaws is hereby amended by inserting the word "Recovery" into the last phrase of Section 1.00 STANDING COMMITTEES of the bylaws so that the phrase "and the Physicians Committee" is amended to read "and the Physician Recovery Committee."

Section 6.00 and 6.01 are hereby repealed and replaced with the following language:

Section 6.00 PHYSICIAN RECOVERY COMMITTEE. The committee shall be comprised of at least 15 members appointed by the President. Additional appointments may be made from time to time as needs of the committee dictate.

6.01 DUTIES. The committee shall establish a statewide non-coercive advocacy program for locating, contacting, and offering rehabilitative help to physicians whose professional competency has been impaired because of alcoholism, chemical dependency, or substance abuse. It shall continue to work in liaison with the State Board of Medical Examiners and shall establish programs of education and prevention concerned with alcoholism and other chemical dependence. It shall educate, identify, verify, intervene, direct to treatment and evaluate for re-entry into the active profession the affected physician.

6.02 DIRECTOR. The Physician Recovery Program shall be administered by a Director to be selected by the Board of Trustees.

6.03 RULES. The committee shall develop and administer its own procedure rules to meet the requirements of the DUTIES outlined in 6.01 above.

The entire Bylaws of the Oklahoma State Medical Association are hereby amended to remove all reference to the "Physicians Committee" and replace them with "Physician Recovery Committee."

### Recommendation

The Constitution and Bylaws Committee recommends that the proposed amendments above be adopted.



## House Cleaning Amendments

The following series of proposed amendments to the OSMA Bylaws are designed to correct the language and/or bring them into compliance with the American Medical Association Bylaws. These are "house cleaning amendments" and do not make substantive changes in the bylaws.

**Resident Members** — The Bylaws of the Oklahoma State Medical Association are hereby amended to replace the phrase "Junior Members" with the phrase "Resident Members" whenever it shall appear in the bylaws. The word "Junior" shall be replaced with the word "Resident" wherever it shall appear. This shall include, but not be limited to, Chapter I, Sections 2.00, 2.05, 2.051, 4.00, and Chapter II, Section 1.034.

This amendment simply brings the OSMA Bylaws into agreement with those of the American Medical Association. The term "Junior Member" was originally used to designate either a resident or intern.

**Vice-Chairman, Board of Trustees** — Section 5.02 of Chapter V is hereby amended so that the third full grammatical sentence reads, "The Vice-Chairman shall preside in the absence of the Chairman of the Board, *or at the discretion of the Chairman.*" The remainder of this section remains unchanged.

This simply amends the bylaws to provide that the Vice-Chairman can preside at a Board meeting even when the Chairman is present.

**Secretary-Treasurer** — Chapter VII, Section 4.00. The fourth full grammatical sentence is amended to read as follows: "He shall be custodian of all funds of the Association and shall make all authorized disbursements on vouchers signed by the Executive Director. ~~and counter signed by the President.~~"

This amendment removes from the bylaws the section requiring that vouchers be counter signed by the Association President. This particular procedure was discontinued many years ago at the suggestion of the Association's accounting firm.

**Councils** — Section 1.00, Chapter IX, is amended by adding the phrase "Council on Medical Services" between the phrases "Council on Members Services" and "Council on Governmental Activities."

This is a corrective amendment to add the Council on Medical Services to the list of other OSMA Councils appearing in Section 1.00. It was inadvertently omitted the last time the bylaws were changed.

## Recommendation

The Constitution and Bylaws Committee recommends that all four house cleaning amendments be adopted.

## House of Delegate Sections

The OSMA Planning and Development Council has recommended that the House of Delegates consider creating three delegate sections with full voting power. These would be a Medical Student Section, Resident Physician Section, and Hospital Medical Staff Section. Each section would be treated the same as a component medical society, but would be entitled to only one delegate and one alternate delegate each.

In order to create the special delegate sections two separate actions must occur: First, the Constitution of the OSMA must be amended to provide four delegate sections

under the article outlining the make-up of the House of Delegates. Second, the Bylaws of the Association must be amended to provide for the section representation in the House and the necessary mechanism to allow the sections to organize.

In order to create the special voting sections, the Constitution of the Association must be amended. Because of a constitutional provision requiring that all component societies must be given 60 days notice of any proposed constitutional amendment, it will not be possible for this year's House of Delegates to formalize the creation of the special sections. But the House can lay the ground work for the creation of the special sections by adopting the necessary bylaws amendments, with the provision that they will not become operational until or unless the House of Delegates in 1986 adopts the necessary constitutional amendment.

By going ahead and adopting the bylaws amendments this year, it would allow the special sections to form, on an ex-officio basis, this fall or winter, and to establish the necessary rules or regulations for their future operation.

In addition, they could elect or select their delegates to participate in the 1986 House of Delegates meeting under the bylaws provision that allows the Speaker of the House of Delegates to grant privilege of the floor, i.e., the right to speak and participate in debate, but not to vote, to any visitor. Thus, the special sections could be seated on the floor of the House of Delegates and could actively participate in activities in 1986.

However, their further participation in the House of Delegates would be predicated upon the 1986 delegates adopting the appropriate constitutional amendment necessary to formalize the creation of the special sections.

Further, by adopting the necessary bylaws changes, the 1985 House of Delegates would be signaling to the 1986 House of Delegates they felt that the special sections were worthwhile and appropriate. However, the 1986 House of Delegates would still have the option of approving or rejecting the special sections by approving or rejecting the proposed constitutional amendment.

The constitutional amendment that would be officially considered in 1986 would be as follows:

ARTICLE V of the Constitution of the Oklahoma State Medical Association is hereby amended to read,

"Section 1. The House of Delegates shall be the elective body of the Association. It shall be composed of: (1) Delegates elected by the component societies; (2) General officers of the Association; (3) All other members of the Board of Trustees and Alternate Trustees; ~~and~~ (4) Delegates and Alternate Delegates to the American Medical Association; and (5) *Delegates representing special sections.*"

The italicized portion above would be the new language.

## Bylaws Amendments (RE: Delegate Sections)

The Planning and Development Council recommended that the House of Delegates consider creating three special delegate sections: Medical Student Section, Resident Physician Section, and Hospital Medical Staff Section.

It is conceivable that the House of Delegates may determine that it wishes to create all three new sections, only one or two new sections, or no sections at all.



In the latter event, the House of Delegates would simply take no action at all. However, if it wished to create one, two or three new sections, the bylaws would have to be amended in a slightly different manner for each alternative.

In the event the House of Delegates wishes to create three new special sections, the following language should be adopted:

Chapter IV, Section 1.00 is amended as follows:

"Section 1.00 COMPOSITION. The House of Delegates shall be composed of the general officers of the Association, Delegates and Alternate Delegates to the American Medical Association, Trustees and Alternate Trustees, Delegates elected by the component societies, and ~~two non-voting delegates to be elected by each American Medical Student Association chapter located in an educational institution approved by the Board of Trustees. Delegates elected by the sections recognized in Section 1.04 below.~~"

Section 1.04 of Chapter IV is repealed in its entirety. This is the section creating Medical Student Association non-voting delegates.

A new section 1.04 is created to read as follows:

"1.04 SECTION REPRESENTATION. The following sections shall be entitled to one delegate and alternate delegate each: Medical Student Section, Resident Physician Section, and Hospital Medical Staff Section."

Section 2.00 of Chapter IV is amended to read as follows:

"Section 2.00 ELECTION AND TERM OF OFFICE. Delegates and Alternate Delegates shall be elected in November or December by component societies. Certification of Delegates and Alternate Delegates shall commence on January 15 following their election by component societies, and shall continue in effect for a period of one year. *Provided, however, that the special sections may elect their Delegates and Alternate Delegates any time prior to December 31, so that they may serve during the next year.*"



Sally Berger and Carl Stonecipher take their places in the House of Delegates as representatives of the University of Oklahoma medical students.

In order to provide for the organization of the special sections, Chapter IV is amended to create a new Section 11.00 as follows:

"Section 11.00 SPECIAL SECTIONS. The special sections, as recognized in these bylaws, shall be organized and shall function according to rules established by the Board of Trustees. The rules adopted shall include, but shall not be limited to, a mechanism allowing each section to choose its Delegate and Alternate Delegate. Provided, however, that the Trustees may impose different mechanisms on different sections as needed."

#### **Creation of Two Special Delegate Sections**

In the event the House of Delegates should determine it wishes to form only a Resident Physician Section and Hospital Medical Staff Section, it should adopt the following bylaw amendments:

Section 1.00 of Chapter IV, should be amended by inserting the phrase "Delegates elected by the special sections," just after the phrase "Delegates elected by the component societies," and just before the phrase "and two non-voting delegates . . ." etc.

A new section, 1.06, should be created as follows:

"1.06 SPECIAL SECTIONS. The following special sections shall be entitled to one Delegate and one Alternate Delegate each to be elected by the section according to Section 2.00, below: Resident Physicians Section, and Hospital Medical Staff Section."

Section 2.00 of Chapter IV is amended to read as follows:

"Section 2.00. ELECTION AND TERM OF OFFICE. Delegates and Alternate Delegates shall be elected in November or December by component societies. Certification of Delegates and Alternate Delegates shall commence on January 15 following their election by component societies, and shall continue in effect for a period of one year. *Provided, however, that the special sections may elect their Delegates and Alternate Delegates any time prior to December 31, so that they may serve during the next year.*"

Chapter IV is amended by creating a new Section 11.00, as follows:

"Section 11.00 SPECIAL SECTIONS. The special sections, as recognized in these bylaws, shall be organized and shall function according to rules established by the Board of Trustees. The rules adopted shall include, but shall not be limited to, a mechanism allowing each section to choose its Delegate and Alternate Delegate. Provided, however, that the Trustees may impose different mechanisms on different sections as needed."

In the event the House chooses to form only a Resident Physician Section or a Hospital Medical Staff Section, the amendments outlined immediately above should be adopted, but the name of the section not desired should be deleted.

The Constitution and Bylaws Committee makes *no* recommendation regarding the creation of special House of Delegate sections.

Respectfully submitted,  
Floyd F. Miller, MD, Chairman  
Larry L. Long, MD, Vice-Chairman  
David Browning, Jr., MD  
Jerold D. Kethley, MD  
Arnold G. Nelson, MD  
J. B. Wallace, MD



## Report of the PHYSICIANS LIABILITY INSURANCE COMPANY

Referred to: Reference Committee I

At the conclusion of its fifth year of operations on December 31, 1984, the Physicians Liability Insurance Company continued to perform well in meeting the objectives of providing low-cost, high quality professional liability and health insurance coverage to members of the Oklahoma State Medical Association.

Your company's relatively superior performance in these two insurance lines which are noted for their high-risk and volatility is especially remarkable in light of the worsening claims pressures and heavy underwriting deficits which prevailed nationally.

### Professional Liability Program

In 1984, the nation's property and casualty insurers sustained a \$21.3 billion underwriting loss. The combined loss ratio for all coverage lines in this category was 117.8% — a 5.8% increase over 1983 and the worst year-to-year jump since 1973-74 which, coincidentally, was at the midpoint of the "malpractice crisis years of the 70's."

The nation's insurers' *worst-performing* coverage line was *medical professional liability insurance*, which turned in an underwriting *loss ratio of 169.7%!*

Despite the industry-wide disaster year of '84, PLICO's professional liability insurance program operated smoothly on a break-even basis even though it maintained its 4-year position of having the nation's lowest premium structure. Not only did PLICO offer the most economical rates for high-quality occurrence-type coverage, but it was also priced below the "mature" rates of the less-than-desirable "claims-made" policies which now dominate the professional liability market.

A "claims-made" policy begins with a low first-year premium but escalates sharply over the next four years until a so-called mature rate is achieved.

The "claims-made" name is descriptive of the policy's coverage limitation, because the company using this policy form will only honor claims "made" against it while the policy is in force. A physician who terminates such an insurance plan (or is cancelled) will have no coverage for late-blooming claims based on a prior period of practice unless an "extended reporting endorsement" is purchased from the claims-made carrier within 30 days after the termination date — the premium for which can be as high as two or three times the *annual* premium previously paid.

Professional liability reinsurance companies were heavy losers in 1984. Because of this adversity, the reinsurance market contracted and sharp rate increases were the rule for 1985 renewals. PLICO, which relies on reinsurance to extend its coverage limit options to as high as \$5,000,000, sustained a rate increase reflective of the national loss picture and it was necessary to effect a "pass-through" rate increase for 1985. Yet PLICO's relative pricing superiority remained unchanged — your company is still the nation's frontrunner. For example, PLICO's highest premium for 1985 is \$10,953 but a physician in the same risk class would pay \$80,000 in New York.

The position of PLICO in the professional liability milieu continues to be bright during an era when the best position attainable is at the low end of the "misery scale." The biggest problem for your company, however, is the sharp decline in the number of reinsurers which continue to market occurrence-type high limit protection. Your Board of Directors and its management company are shopping the world reinsurance markets now for the 1986 renewal — every possible effort will be made to maintain the *occurrence-type* program which Oklahoma physicians have always enjoyed — and at a price which will sustain PLICO's leadership role.

Your Board of Directors knows that OSMA-wide loyalty and commonality of purpose will continue. These characteristics have been the greatest strength of our association's professional liability program since 1952 — the year when the OSMA inaugurated the first association-sponsored group malpractice program in the nation. To keep rating fair for every Oklahoma physician, PLICO will continue to conform to the risk class rating system adopted by the Insurance Services Office.

Moving to the eight-class system was postponed for one year, but the time has come when it must be made. Our statistics are insufficient to make rates for Oklahoma exclusive of the rest of the United States for each specialty and, to see to it that every Oklahoma physician participates on an equal basis in the savings generated by good Oklahoma loss experience, the new system must be adopted.

This changeover to the eight-class system will occur on the 1986 renewal date. A complete program disseminating information will be carried out in advance, including visits to all of the county medical society meetings; and additionally, discussions regarding the impact of the eight-class system will occur at the Loss Control Seminars next August. Mailings will also be sent to all physicians affected by the changeover, advising them individually as to the impact on their particular practices.

There will be changes — both increases and decreases — relative to the five-class system, but it must be understood that none of these can be priced at this time because it is yet to be known what reinsurance will cost in 1986. Whatever the change, all physicians will equally participate in the lower premiums resulting from Oklahoma's superior loss experience. Their share of the savings will be determined by national loss experience, as it must be,

because there are not enough physicians within any one specialty in Oklahoma to make risk class rates exclusively for Oklahoma. The object of your company is to fairly distribute the savings which Oklahoma physicians have created together through their good medical practices and should share together in 1986. Regardless of risk class, your premium will be less than that of the only competitor in Oklahoma — and even less than any other physician practicing your specialty in the United States.

Some of the physicians serving on the PLICO Board of Directors will receive increases as well, but the vote was unanimous to go to the new classification system because they believed it to be the fairest system available for us all.

The reclassification program is a task which cannot be delayed. Your Board of Directors seeks your cooperation and understanding.

As of December 31, 1984, 1,628 professional liability claims had been registered against state physicians since the inception of the company, an increase of 498 claims since December 31, 1983. During the year, 88 claims were paid in the total of \$7,965,785, \$4,453,896 of which was paid by PLICO's reinsurer and \$3,511,889 of the loss was paid directly by PLICO.

Since PLICO's inception in 1980 through December 31, 1985, 206 claims have been paid in the total amount of \$14,664,621, \$6,268,029 of which was paid by your company's reinsurer and \$8,369,592 was paid directly by PLICO.

There are about 3,800 physicians participating in PLICO's professional liability program — a number which has been growing in direct ratio with our expanding profession from year to year.

### PLICO Health

The fine service of PLICO's major medical and hospital program can best be illustrated by the payout to physicians, their employees and their respective dependents during 1984: 38,556 claims were processed in the total amount of \$9,065,058.

During the year, it was necessary for PLICO to discontinue the \$100 annual deductible option and to increase the premium rates on another occasion. These actions were direct responses to loss experience.

The program increase effected in May improved the operating soundness of the program over the last half of the year, but it did not generate enough additional revenue to offset first half losses plus the cost of paying the Wellness Bonus carryover from 1983. The Wellness Bonus, designed as an incentive to deter claims for minor health maintenance expenses, proved to be unsuccessful with younger physicians and was abandoned. It is now history for the under-65 group of PLICO insureds.

The program's operating deficit, accrued since inception, will soon be resolved. An operating surplus for the first two months of 1985 was encouraging, but insufficient to deal expeditiously with the deficit of prior years. Therefore, on May 1, 1985, the premium rates were increased by the PLICO Board of Directors and the minimum annual deductible was raised to \$300. These actions are expected to bring the program back into balance over the next 12 months. Meanwhile, the PLICO Health price/benefit package continues to meet or better the competition.

On December 31, 1984, there were 2,543 PLICO Health policies in force for physicians and 5,500 policies had been issued to their employees.

### Financial Condition

Assets at the year-end were \$25,921,878 — up \$3,451,235 from 1983. Premiums written for the professional liability and health insurance programs were \$22,462,312 for the year, and investment income realized \$2,924,537.

#### Physicians Liability Insurance Company Balance Sheet Year Ended December 31, 1984

<b>Assets</b>	
Cash and Invested Assets	\$24,675,341
Premium Prepaid	(32,651)
Reinsurance Recoverable on Loss	
Payments	93,261
Interest Receivable	517,701
Receivable from OSMA	652,500
Other	15,726
Total Assets	<u>\$25,921,878</u>
<b>Liabilities</b>	
Unearned Premium	\$ 2,789,432
Losses and Loss Adjustment	
Expenses	19,623,374
Miscellaneous Accounts Payable	4,543
Total Liabilities	<u>22,417,349</u>
<b>Stockholder's Equity</b>	
Common Stock	150,000
Additional Paid-In Capital	4,350,000
Deficit	(995,471)
Total Stockholder's Equity	<u>3,504,529</u>
Total Liabilities and Stockholder's Equity	<u>\$25,921,878</u>

#### Statement of Operations Year Ended December 31, 1984

<b>Revenues</b>	
Earned Premiums	\$18,161,513
Investment Income	2,924,537
Recovery of Bad Debt	4,970
Total Revenues	<u>21,091,020</u>
<b>Expenses</b>	
Losses	15,444,888
Loss Adjustment Expenses	2,999,092
Operating Expenses	3,064,455
Total Expenses	<u>21,508,435</u>
Loss	(417,415)
Deficit, Beginning of Year	(578,056)
Deficit, End of Year	<u>\$ (995,471)</u>



## Report of the OKLAHOMA STATE MEDICAL ASSOCIATION AUXILIARY

Subject: **Annual Report**

Presented by: Mrs. Pam Oster, President

Referred to: Reference Committee I

"Invest in the Future — Bank on OSMA Auxiliary" has been our theme for 1984-85. Across the state auxiliaries have "INVESTED" much time and effort to bring about great "GAINS" in health awareness for all Oklahomans.

At the state level, August brought the first public service announcement sponsored by the Auxiliary dealing with childhood immunizations. KOCO-TV, Channel 5 in Oklahoma City, produced and distributed the 20-second spot and three other television stations, unsolicited, also aired the message. Scripts were sent to county auxiliaries along with a letter asking them to have their local radio stations run the message.

Our second annual fall confluence held in September brought several topics to the attention of our members. The main focus of the meeting was "Health Improvement Programs in Elementary Schools." Other topics addressed were legislation, health projects, latchkey children, prenatal and postnatal care, and workshops on AMA-ERF and membership. Our thanks to the OSMA for the financial support that enabled us to offer this meeting to our members.

Also in September, a multi-county meeting was organized and hosted by the Stephens County Auxiliary. Members from five counties were invited to lunch at the new Duncan hospital. For this special meeting, AMA Auxiliary Southern Regional Vice-President, Virginia Kutait from Fort Smith, Arkansas, presented a program on the importance of Auxiliary.

We continued our efforts to install our organ donor posters in all tag agencies across the state. Several counties asked for extra posters to hang in their local hospital emergency rooms. The posters ask, "If your child needed a vital organ to live, would one be available? Please sign an organ donor card today!"

Another all-time high is the report from AMA-ERF. As of April 1, \$27,399 has been raised. With the auction at this convention we hope to reach our goal of \$30,000.

The February "Day at the Capitol" brought members together to learn about legislation concerning consolidation of state licensing boards, toxic waste disposal and other issues. Speakers include State Senate President Pro Tempore Rodger Randle, Representative Rebecca Hamilton, and Robert Baker and Otie Ann Carr of OSMA.

At the county level members have baked, sold, auctioned, raffled, played basketball and tennis, and participated in a multitude of other activities to raise money for worthwhile projects. They have worked for legislation concerning seatbelt safety and stiffer penalties for drunk driving. Some have donated blood, held science and health fairs, taught CPR, installed "Life Lines" and organized social functions for the elderly. Others have supported, both financially and physically, programs on drug and alcohol

abuse prevention, hearing and vision screening in schools, and fingerprinting children. These are but a few of the many projects undertaken by Oklahoma Auxilians.

I am proud to be a member of this fine organization and honored to serve as their president. It has been a rewarding and productive year. We would like to thank the OSMA for the support and encouragement they have given us, and we hope our alliance will continue to grow and flourish, for together we can do so much more!

Respectfully submitted,  
Pamela A. Oster  
President

## RESOLUTION 4

(Not Adopted)

Introduced by: Cleveland-McClain County  
Medical Society

Subject: **Outpatient Psychiatric Services**

Referred to: Reference Committee I

WHEREAS, Psychiatric care is a basic and essential part of medical care; and

WHEREAS, PLICO does not provide for the payment of outpatient psychiatric services; and

WHEREAS, The House of Delegates is the official representative Body of the OSMA membership; now therefore be it

*Resolved*, That the House of Delegates hereby instructs the Board of Directors of PLICO to modify its PLICO Health policy to include coverage for outpatient psychiatric services; and be it further

*Resolved*, That the Board of Directors of PLICO present a proposal to the House of Delegates in 1986 to include outpatient psychiatric care under PLICO coverage.

## SUBSTITUTE RESOLUTION

(Adopted in Lieu of Resolution 4)

Introduced by: Reference Committee I

Subject: **Outpatient Psychiatric Services**

Referred to: OSMA House of Delegates

*Resolved*, That the House of Delegates hereby requests the Board of Directors of PLICO to modify its PLICO Health psychiatric services; and be it further

*Resolved*, That the Board of Directors of PLICO present a proposal to the House of Delegates in 1986 to include broader outpatient psychiatric care under PLICO coverage.

## RESOLUTION 6

(Not Adopted)

Introduced by: LeRoy C. Mims, MD  
Subject: **University of Oklahoma Tulsa Medical College**

Referred to: Reference Committee I

WHEREAS, Most Tulsa physicians are aware of the rapid increase in numbers of physicians in the Tulsa metropolitan area created by three (3) active institutions of higher medical education; and

WHEREAS, This rise in the number of salaried physicians who are also allowed to develop private practice has led to an unbalanced doctor/patient ratio; and

WHEREAS, The accessibility to state-supported health care facilities are open to all patients regardless of ability to pay, but the numbers accepted into such facilities are limited under pre-set quotas; and

WHEREAS, The pre-set quota system works against those less fortunate patients who cannot afford transportation to attend state facilities and thus encourages those patients who should be considered a part of the private patient population; and

WHEREAS, The oversupply of physicians in the State of Oklahoma in general, and specifically in Tulsa, Oklahoma, may have an adverse effect on both the quality and cost of medical care; and

WHEREAS, This increase doctor/patient ratio has also created an unhealthy economic market for private practicing physicians who receive no salaries from the State; and

WHEREAS, The unhealthy economic marketplace has allowed members of the Oklahoma State Medical Association to be manipulated by third-party interests which is threatening the very core of the doctor/patient relationship; now therefore be it

*Resolved*, That the Oklahoma State Medical Association request the closure of the University of Oklahoma School of Medicine, Tulsa Branch, as soon as possible.

## RESOLUTION 8

(Not Adopted)

Introduced by: Tulsa County Medical Society  
Subject: **Increased Professional Support of OMPAC**  
Referred to: Reference Committee I

WHEREAS, The Oklahoma Medical Political Action Committee provides significant support to responsible candidates for public office; and

WHEREAS, Oklahoma Medicine is in need of strengthened legislative contacts at both the state and national levels to help assure that the views of physicians are heard in the Congress and the Oklahoma State Legislature; and

WHEREAS, Increased financial support of OMPAC is needed to maximize these avenues of communication and to implement the purposes of the organization; now therefore be it

*Resolved*, That the Oklahoma State Medical Association encourage the Oklahoma Medical Political Action Committee to mount an intensive campaign designed to increase physician giving and the amount of contributions; and be it further

*Resolved*, That OMPAC be encouraged to hold meetings for physicians in each county of Oklahoma at which the objectives of the organization and its programs can be explained; and be it further

*Resolved*, That each member of the Oklahoma State Medical Association be encouraged to become a member of the Oklahoma Medical Political Action Committee and voluntarily contribute funds to support its activities.

## RESOLUTION 14

(Adopted as Amended)

Introduced by: Blaine County Medical Society  
Subject: **Impaired Physicians**  
Referred to: Reference Committee I

WHEREAS, We, as physicians are *all* concerned with the reputation of our beloved Medical Profession; and

WHEREAS, The lay press seems intent on exploiting any physician/drug-related story to the detriment of our Medical Profession; and

WHEREAS, Repeated impaired physician incidents lend to polarization of public opinion regarding our profession (especially in the smaller communities); and

WHEREAS, It is our duty as delineated in the Code of Ethics of the American Medical Association to protect the unsuspecting public from possible danger; and

WHEREAS, We realize that the House of Delegates wields no authority whatsoever over the Oklahoma State Board of Medical Examiners; now therefore be it

*Resolved*, That the House of Delegates of the Oklahoma State Medical Association implore the Oklahoma State Board of Medical Examiners to take proper heed and to more actively pursue earlier ~~delicensure~~ disciplinary/rehabilitative action regarding cases of repeatedly offending drug-impaired physicians, both for the good of the public in general and the medical profession as a whole.

## RESOLUTION 15

(Not Adopted)

Introduced by: Council on State Legislation  
Council on Governmental Activities  
Subject: **OMPAC Membership**  
Referred to: Reference Committee I

WHEREAS, health legislation, government restrictions and numerous opposing factions have caused and are causing ever increasing problems for the medical profession and patients; and

WHEREAS, the future of medicine and that of our patients is being jeopardized by ever increasing government intrusion; and

WHEREAS, organized medicine in Oklahoma has an effective yet under supported mechanism, to promote proper medical issues, known as OMPAC; and



WHEREAS, since its inception, OMPAC has never had over 20% of OSMA membership in OMPAC; and

WHEREAS, a minimum contribution to OMPAC from every OSMA physician would enable OMPAC to become the largest PAC in the federation, as well as a leader in the state; and;

WHEREAS, the amount of political involvement by every physician is directly attributable to the success or failure of our legislative issues and elections; now therefore, be it

*Resolved*, that the Council on State Legislation and Council on Governmental Activities recommend that every physician member of the OSMA contribute the minimum membership of fifty dollars (\$50.00) to OMPAC and wholeheartedly urge all members to increase their membership where feasible.

## **SUBSTITUTE RESOLUTION**

(Adopted in Lieu of Resolutions 8 & 15)

Introduced by: Reference Committee I

Subject: **OMPAC Membership**

Referred to: OSMA House of Delegates

*Resolved*, That the Oklahoma State Medical Association encourage the Oklahoma Medical Political Action Committee to mount an intensive campaign designed to increase physician giving and the amount of contributions; and be it further

*Resolved*, The OMPAC be encouraged to hold meetings for physicians in each county of Oklahoma at which the objectives of the organization and its programs can be explained; and be it further

*Resolved*, That the Council on State Legislation and the Council on Governmental Activities encourage that every physician member of the OSMA contribute the minimum membership of fifty dollars (\$50.00) to OMPAC and wholeheartedly urge all members to increase their membership where feasible.

Late Resolution

## **RESOLUTION 17**

(Adopted)

Introduced by: Council on Member Services

Subject: **For-Profit Service Corporation**

Referred to: Reference Committee I

WHEREAS, Many state and county medical associations are finding it both convenient and profitable to form separate, wholly-owned, for-profit corporations; and

WHEREAS, The purpose of such corporations is to provide services and conduct programs that the Association may want to offer its membership, but would have trouble doing so because of the "for-profit" nature of the activity; and

WHEREAS, The Internal Revenue Service does not look favorably upon nonprofit corporations, such as the OSMA, that are involved in any activity that creates a profit accounting for 20%-25% of its total income; and

WHEREAS, Such a for-profit, wholly-owned subsidiary could be utilized by the Association to avoid involvement with the IRS and at the same time provide needed services to Association members such as printing, disposable medical supplies, automobile leasing, bank card collection systems, etc.; now therefore be it

*Resolved*, That the House of Delegates authorize the OSMA Board of Trustees to study the feasibility and advisability of creating such a corporation; and be it further

*Resolved*, That if the Board of Trustees feels that such a for-profit corporation is justified, that it be authorized to create such a corporation as a wholly-owned subsidiary of the OSMA and under the Association's management and control.

Late Resolution

## **RESOLUTION 18**

(Adopted as Amended)

Introduced by: Council on Member Services

Subject: **PLICO Appeal Mechanism**

Referred to: Reference Committee I

WHEREAS, Under the present Underwriting Plan for PLICO, the Council on Member Services of the OSMA serves as the Underwriting Committee; and

WHEREAS, A recommendation by the Underwriting Committee must first be considered by the PLICO Board of Directors, and if the physician involved is dissatisfied with his finding, he has the right to appeal to the OSMA Board of Trustees; and

WHEREAS, This multiple appeal mechanism may take several months, during which time the physician either has no insurance coverage or poses a greater loss-risk to PLICO; and

WHEREAS, This appeal delay can work a hardship on the physician without insurance or expose PLICO to an unnecessary risk; now therefore be it

*Resolved*, That the House of Delegates hereby alter the OSMA-PLICO Underwriting Plan to provide that an underwriting decision by the PLICO Board of Directors shall be final and that the second appeal to the OSMA Board of Trustees shall be eliminated.

# REPORTS to the OSMA House of Delegates Referred to Reference Committee II

## Report of the COUNCIL ON PROFESSIONAL AND PUBLIC RELATIONS

Subject: **Annual Report**

Presented by: M. Joe Crosthwait, MD, Chairman

Referred to: Reference Committee II

### Introduction

The Council on Professional and Public Relations is responsible for the internal and external communications program of the Oklahoma State Medical Association. The overall goals of the Council are (1) to improve and maintain understanding among Oklahoma physicians, their patients and the public; and (2) to keep members informed about programs, policies and activities undertaken by the Association affecting the practice of medicine in Oklahoma.

With the approval of the OSMA Board of Trustees, the Council's main goal this year will be production of a one-half hour film dealing with the condition of American medicine.

The Council has contracted with Tulsa Studio Productions, Inc., to write and produce the film.

The Council plans to purchase air time to broadcast the film on Oklahoma television stations and then make the film available to hospitals and other business and civic groups.

The Council plans to market the finished product to other state and county medical societies in an effort to recoup as much of the production costs as possible.

With the assistance of the OSMA Auxiliary, the Council plans to greatly increase the range of distribution for the popular Medical Update series. The auxiliaries have agreed to undertake as a county level project an effort to deliver Medical Update holders and brochures to physician offices.

The Council also will seek budget approval to update and reprint the Association's basic brochure, "A Proud Heritage . . . The Oklahoma State Medical Association." The supply of the brochure is completely depleted.

The Council will continue to actively fund and support the OSMA's medical student program. Annual picnics in Oklahoma City and Tulsa, roundtable luncheons on medical issues in both cities, and advanced seminars with state and national policymakers for selected students and physicians have produced a dramatic increase in OSMA medical student membership.

There are now 215 medical student members of the OSMA.

The Council held a very successful initial meeting of an OSMA speakers bureau and will implement the program in this fiscal year.

The Council will continue to publish the *OSMA News*, contribute to the *JOURNAL* of the Oklahoma State Medical Association, and work closely with members of the Oklahoma news media to provide both news and public service information to the citizens of Oklahoma.

Specific recommendations of the Council on Professional and Public Relations for 1985-86, along with budgetary requirements, are:

1. Produce documentary film . . . . .	\$ 87,300.00
2. Purchase air and promotional time for film . . . . .	15,000.00
3. Medical student programs . . . . .	4,500.00
4. Reprint "Medical Brochure" . . . . .	7,000.00
5. Print <i>OSMA News</i> . . . . .	8,000.00
6. Print Medical Updates . . . . .	3,000.00
7. Educational activities and professional dues . . . . .	2,500.00
8. Speakers Bureau . . . . .	1,000.00
9. Community service projects . . . . .	1,000.00
Total	\$129,300.00

Respectfully submitted,  
M. Joe Crosthwait, MD, Chairman  
Howard A. Bennett, MD  
Warren V. Filley, MD  
Burdge F. Green, MD  
Edward Jenkins, MD  
Mary Anne McCaffree, MD  
G. L. Massad, MD  
Jerry L. Puls, MD  
L. E. Schoeffler, MD  
Michael Talley, MD  
Lanny Trotter, MD  
M. Michael Sulzycki, OSMA Staff

## Report of the COUNCIL ON PUBLIC AND MENTAL HEALTH

(Adopted as Amended)

Subject: **Annual Report**

Presented by: George W. Prothro, MD, Chairman

Referred to: Reference Committee II

### Introduction

It is the goal of the Council on Public and Mental Health to provide the citizens of this state, as well as OSMA members, with timely information regarding the medical aspects of public and mental health and to conduct and oversee needed programs in these areas.



## Review of Activities

The Council strongly supported the August 1984 referendum seeking an increase in millage to support public health programs. Flyers supporting the measure were distributed to all OSMA members and thousands were reprinted, with the permission of the OSMA, by the Tulsa County Health Department. Despite this support, the measure failed to pass due largely to the inaccurate wording on the referendum ballot.

The Council otherwise dispensed its responsibilities contained in the Council's 1984 report approved by the House of Delegates.

The Council also reports as an information item that the Oklahoma Health Education Advisory Council voluntarily has disbanded. The Council and many other medical and civic groups supported OHEAC in its goal to secure state funding for health education programs for Oklahoma elementary schools. With funding appropriated and several programs in operation, OHEAC had accomplished its goal.

## Objectives

A. *Medical Research* — Since Oklahoma State Law, Title 63, Section 2601, prohibits medical research involving minors, the Council, with approval from the OSMA Board of Trustees, recommends the language in the law be amended to "permit research, as approved by an appropriate institutional review board, on minors for reportable communicable diseases."

The Council will work with the OSMA's Council on State Legislation and Council on Professional and Public Relations to seek this amendment from the next session of the Oklahoma Legislature.

B. *Medical Education* — The Council, with OSMA Board of Trustees endorsement, feels the closer integration of the psychiatry residency programs conducted by the OU College of Medicine and State Mental Hospitals would both enhance patient care and the quality of psychiatric training.

The Council recommends adoption of a resolution supporting the concept and will work with appropriate state and university officials for its implementation.

C. *Maternal Mortality Committee* — ~~This committee is established by an Oklahoma statute and operates independently of our Council and the Association.~~ The annual report was submitted to the Council.

D. *Perinatal Task Force* — The Governor has established an advisory group on perinatal care in Oklahoma. The Council will continue to support and seek input from the perinatal group.

E. *Nutrition Committee* — The committee met February 22 and plans to be active this year.

F. *Sports Medicine Committee* — The Council also plans to reactivate the Sports Medicine Committee this year.

## Recommendations

1. Support and follow resolution introduced by this committee.
2. Work to amend Oklahoma State Law, Title 63, Section 2601.
3. Continue the activities as outlined by this report.
4. Approve the requested fiscal notes of this council.

## Budget Requests

Council and committee expenses . . . . .	\$ 500.00
Maternal Mortality Committee . . . . .	250.00
Other Council programs and internal education programs . . . . .	500.00
Total . . . . .	1,250.00

Respectfully submitted,  
George W. Prothro, MD, Chairman  
Frank L. Adelman, MD  
Edgar W. Cleaver, MD  
Gordon H. Deckert, MD  
Sara R. Depersio, MD  
Hayden H. Donahue, MD  
John W. Drake, MD  
Jodie Edge, MD  
George B. Gathers, MD  
William G. Harvey, MD  
Roger B. Hensley, MD  
Jerry R. Hordinsky, MD  
Joe B. Jarman, Jr., MD  
Bertha M. Levy, MD  
Robert Mahaffey, MD  
John S. Muchmore, MD  
Jerry Nida, MD  
Edward K. Norfleet, MD  
Hal B. Vorse, MD

## Report of the COUNCIL ON MEDICAL EDUCATION

Subject: **Annual Report**

Presented by: William R. Smith, MD, Chairman

Referred to: Reference Committee II

## Introduction

The council shall study and make recommendations related to all matters of maintaining or improving the level of competency of physicians in Oklahoma, including but not limited to, maintaining liaison with the medical education colleges in Oklahoma, to conducting continuing medical education courses for association members, and to the accrediting of medical education programs in Oklahoma. It will also monitor continuing medical education standards as they may be required by association policy.

## Review of Activities

A. *Continuing Medical Education Survey and Accreditation Program* — An important activity of the council is the survey and accreditation program. The council continues its activities of surveying and certifying for accreditation the continuing medical education programs of Oklahoma hospitals and independent organizations which meet the requirements. The OSMA has the sole responsibility, an extension of the national accrediting group, the Accreditation Council on Continuing Education, of approving state CME programs.

At the present time the following institutions are fully accredited to produce Category I continuing medical education offerings:

Baptist Medical Center, Oklahoma City  
 Duncan Regional Hospital, Duncan  
 Hillcrest Medical Center, Tulsa  
 Mercy Health Center, Oklahoma City  
 Presbyterian Hospital, Oklahoma City  
 South Community Hospital, Oklahoma City  
 Saint Anthony Hospital, Oklahoma City  
 Saint Francis Hospital, Tulsa  
 Saint John Medical Center, Tulsa

The OSMA Council on Medical Education was recently surveyed by the ACCME to continue its accreditation as a surveying entity. We feel the survey went very well, but we will not know the results until later this year.

At various times throughout the year, OSMA staff and some physicians may be asked by the ACCME to act as surveyors for other state medical association accreditation surveys.

**B. Physician Manpower Study** — The Oklahoma State Regents for Higher Education Advisory Committee on Physician Manpower is continuing to study the issue of how many physicians Oklahoma actually needs. They have had several meetings since October, 1984, and plan to have their study completed and ready for recommendation to the Regents by the first of July.

Our council has been asked and has agreed to assist the Advisory Committee by reviewing data. We also produced a "white paper" (Attachment A) which was mailed to the Board of Trustees and adopted as an official OSMA position, prior to being presented to the Advisory Committee last month.

The Advisory Committee's membership includes the following OSMA members: Billy D. Dotter, MD, Okeene; Larry D. Edwards, MD, Tulsa; George H. Kamp, MD, Tulsa; Joan Leavitt, MD, Oklahoma City; C.S. Lewis, Jr., MD, Tulsa; Charles D. McCall, MD, Oklahoma City; and Clayton Rich, MD, Oklahoma City.

**C. Medical School Liaison** — We are very pleased with the ongoing communication with the medical schools in our state. The representatives of the various institutions who serve on the council are Larry D. Edwards, MD, Dean, Oral Roberts University School of Medicine; Edward Tomsovic, MD, Dean, University of Oklahoma Medical School, Tulsa Branch; and Charles McCall, MD, Dean, University of Oklahoma College of Medicine. The leadership of each of these institutions continue their encouragement of medical students to become involved with organized medicine, as this will be our future.

The proposed sale of the Oklahoma Teaching Hospitals by the Department of Human Services has caused some concern within the OSMA. The council passed, at their January meeting, a policy statement, which was presented to the OSMA Board of Trustees in February. The policy is "The OSMA opposes the transfer of the teaching hospitals to any other authority because it would be detrimental to undergraduate medical education in Oklahoma."

## Recommendations

1. The OSMA continue its support of open communication with the Oklahoma medical schools, and encourage medical students to become more involved in organized medicine.

2. The OSMA support the efforts of the State Regents for Higher Education in their study of health manpower in Oklahoma and provide any assistance the regents feel is necessary.

3. The OSMA actively encourage hospitals and other medical organizations to become accredited to produce continuing medical education programs for the state of Oklahoma.

4. The council continue to send representation to local, state and national education meetings when appropriate.

5. OSMA representatives participate in national accrediting surveys when asked by the Accreditation Council on Continuing Medical Education.

## Budget Requests

Accreditation program .....	\$ 500.00
ACCME survey fee .....	1,000.00
Education opportunities .....	500.00
Total .....	\$2,000.00

Respectfully submitted,  
 William R. Smith, MD, Chairman  
 John R. Alexander, MD  
 Robert C. Bowman, MD  
 Robert T. Buchanan, MD  
 Larry D. Edwards, MD  
 Robert W. King, Jr., MD  
 Steven Landgarten, MD  
 Thomas N. Lynn, Jr., MD  
 Charles B. McCall, MD  
 Harris J. Moreland, MD  
 Victor L. Robards, MD  
 Tim K. Smalley, MD  
 Edward J. Tomsovic, MD  
 Edgar W. Young, Jr., MD  
 Rick Ernest, OSMA Staff

## Attachment A

### PHYSICIAN MANPOWER PRODUCTION CRITIQUE STATE OF OKLAHOMA PREPARED BY THE COUNCIL ON MEDICAL EDUCATION OF THE OKLAHOMA STATE MEDICAL ASSOCIATION

It is the consensus of this Council that in establishing policy for physician manpower production in our state for the foreseeable future, several general principles need to be emphasized.

The *first principle* is that we cannot and must not consider Oklahoma as an isolated entity set apart from the national picture in physician manpower production and utilization.

The *second principle* is that our present methods for predicting physician supply, as well as the health care needs of a specific population, are very limited. Any method that has been used to date is open to some very reasonable criticisms. The GMENAC Report, which has been widely publicized and used extensively for predicting the physician manpower needs nationally and in Oklahoma, will be discussed in detail.

The *third principle* is that any policy affecting first-year medical school slots in this state that is adopted immediately will not affect the medical manpower pool in 1990, but 8 to 10 years from now. The wide swings of the production pendulum should be dampened so that we do not see correspondingly wide swings in production numbers at inappropriate times.

The *fourth principle* is that an honest attempt should be made to arrive at a reasonable output of physicians in our state that will best serve the population, recognizing that an oversupply, with its cost of production to the people of the state as well as the overutilization it could foster, would be just as detrimental as an undersupply of physician manpower.

With these general principles in mind, we think it is appropriate to review the history of physician manpower production nationally and then see how it may apply to our particular situation. The number of medical schools and the number of physicians produced by U.S. medical schools was very stable during the 1940s and 1950s. The Baines Report to the Surgeon General in 1959 noted that the physician population ratio of 141 to 100,000 had been essentially unchanged over a 20-year period. Given the rate of health care utilization during that period, this appeared to be an adequate number. However, with government-generated increases in health services provision and utiliza-



tion and with increasing population, it became obvious that there would soon be a significant reduction in the ability of the available physician pool to provide these services. The Baines Report suggested that medical school graduating classes be increased by 25% and that 20 to 24 new medical schools be established to generate this increase. Urgency was expressed in the following recommendation: "Unless the Federal Government makes emergency financial contribution on a matching basis toward the construction of medical facilities, the nation's physician supply will lag behind the needs created by increasing population."

Four years later, the Health Professional Education Systems Act of 1963 provided the construction funds suggested by the Baines Report, and public policy opinion that there was a "doctor shortage" snowballed. In 1966, the President of the United States established the National Advisory Committee on Health Manpower, with the concept that federal funds in support of capital and operating costs of medical education should be provided to the medical schools, and that these funds should be provided in such a way as to create economic incentives for the schools to expand enrollment. The Health Manpower Act of 1968 provided loans and scholarships for these purposes. In 1970, the Carnegie Commission for Higher Education again expressed urgency and recommended a 50% increase in medical school enrollment.

Medical education responded to the broad social consensus in a totally predictable and expected way by increasing the number of medical schools from 85 to 127 over the period from 1960 to 1982. The first-year enrollment increased from 9,018 to 16,567, which almost doubled the number of first-year medical student slots from 1965 to 1982. During this same period, encouraged by changes in immigration regulations, there was a significant influx of foreign medical graduates, predominantly non-U.S. citizens, into the United States. During the 17-year period from 1965 to 1982, 25 to 30% of first-year residency training program slots were awarded to foreign medical graduates. In this environment, some concerned medical educators, and certainly many of us in medical practice, became concerned that two basic questions were not being asked — the first being, how many physicians are needed, and at what rate should they be produced. The second is how many students should be admitted to medical schools each year to address the nation's need in a reasonable and orderly fashion that would not create significant economic drain on the educational facilities and thus the general public, or produce more physicians than were really needed to supply the wants and needs of our society. Let us shift all of the blame to government and society, it is of interest to recognize that the medical profession itself at this point in history expressed a sense of crisis and urgency as to the medical manpower problem.

In the spring of 1968, joint statements released by the American Medical Association and the American Association of Medical Colleges stated: "The Board of Trustees of the American Medical Association and the Executive Council of the Association of American Medical Colleges emphasizes the urgent and critical need for more physicians if national expectations for health services are to be realized. As a nation, we should address the task of realizing this policy with a sense of great urgency." Thus the medical profession itself gave a clarion call for increased physician production. As you may know, there is an interval of approximately eight years between the entry into medical school of an aspiring physician and his entry into practice. Sharp increases in the medical school enrollment during the 1960s and early 1970s had only a modest effect on the practicing physician supply during that period. In the past three to four years, however, we have begun to hear the terms "physician glut" and "doctor surplus." We must ask ourselves if there is a reason for these concerns on the part of our profession. Some national statistics again will bear out the contention that we should modify the number of physicians we are now producing, but not react again to the cry of crisis to the point of limiting our production to pre-1970 levels. The number of physicians per 100,000 population has increased dramatically in recent years, reaching 212 per 100,000. In 1975 it was 169 per 100,000, and 195 per 100,000 in 1980. This is a 25% increase in the last 20 years. Also notable in this particular study is the number of graduates of foreign medical

schools (including both foreign and U.S. citizens who graduated from these schools and are practicing in the U.S.), which grew 3.6% in a year's period. Since 1973, 1,399 foreign medical grads have come to Oklahoma. These graduates have a significant impact upon the number of actively practicing physicians in our state.

Another disturbing trend is the perception that the quality of physicians produced by the rapidly expanded physician manpower production complex may be inferior to that which might have been produced by a more orderly and less dramatic expansion. The number of applicants applying to medical schools nationally has dropped drastically. In Oklahoma we have gone from 1,474 applicants in 1974 to 850 in 1985. The latest national statistics show that the ratios of applicants to first-year slots are approximately 2 to 1. Ten years ago this ratio was 2.8 to 1, indicating that the Admissions Committees' choice of applicants is truly dwindling. The other disturbing statistic is that the pre-medical grade point average of entering first-year students has decreased progressively over the years from 1979 through the last reported statistics of 1983. The percentage of first-year students having an "A" average (that is a grade point average of 3.6 to 4.0) was 49.2% in 1979, 47.5% in 1980, 45.8% in 1983, 46.4% in 1982, and down to 44.7% in 1983.

Let us now look at the Council's critique of the paper presented to the Health Manpower Advisory Committee on February 28. We have some very real concerns about the basic premises on which this study's conclusions are based. The first would be the sole use of the GMENAC Report to establish the optimal number of physicians per unit population in our state. We have carefully studied the critique of the GMENAC Report by the American College of Physicians, the American College of Surgeons, the American Society of Internal Medicine, the National Advisory Council for Health Professions Education, the American Medical Association, and the Association of Professors of Medicine. There is a common theme running through all of these critiques that we think needs to be emphasized. First, let us state that this is the first detailed specialty-by-specialty study of U.S. physician manpower supply needs which has used a consistent methodology and which has considered variables influencing supply and demand. In this regard, it should be commended. However, there are specific criticisms of the GMENAC approach. The first is that however sophisticated its methodology, GMENAC's inquiry into physician manpower supply and requirements in 1990 is necessarily based on subjective judgments and on informed supposition. Therefore, GMENAC's conclusions must be accepted as approximations or gross estimates, which might be useful in general guidelines to manpower planning, rather than on authoritative, precise facts upon which planners could predicate major revisions in the mechanisms that will influence the supply of physicians, specialties, and subspecialties. Panelists were instructed to formulate their projections on the basis of what should occur in 1990 rather than on what will, might, or could occur. They were also told to assume that there would be no barriers (including financial or geographic) to health care in the 1990s. Considering the economic and political climate in the nation today, projections based upon such instructions may be entirely fallacious. Manpower needs will be dramatically affected by new medical discoveries, major political events, and new delivery systems. Therefore, predictions based upon the GMENAC Report could be regarded at best as estimates or trends, not specific actions.

It is the contention of this Council that the GMENAC recommendation for an ideal physician-to-population ratio of 182 physicians per 100,000 persons is an inflated figure in our present medical environment, for the nation as a whole, and certainly for the State of Oklahoma. However, even if it were assumed that 182 physicians per 100,000 population is the ideal level for the nation, it should be again noted that nationwide, this figure was exceeded by 20 physicians per 100,000 population at the end of 1983. The GMENAC Report itself predicted that there would be 70,000 excess physicians in the U.S. by the year 1990 and 142,000 excess physicians by the year 2000. Based upon this estimate, their recommendation #3 from the Modeling Panel was that allopathic and osteopathic medical schools reduce entering classroom size in the aggregate of a



At the inaugural dinner dance, the Amen family pauses for a picture. From left to right: Richard Amen and his wife, Kittye, from West Allis, Wisc; OSMA President Elvin M. Amen, MD, and his wife, Lucile; and Paula and Douglas Amen, Bartlesville.



minimum of 10% by 1984 relative to the 1978-79 enrollment, or 17% relative to the 1980-81 entering class.

It should be emphasized that planning at the present time must not be based upon 1990 physician manpower needs, as these trainees have already been in the system for approximately three years now. We must target Oklahoma's needs for 1995 and 2000 at the present time. Based on the ideal physician population ratio established by GMENAC and using the tables established by the authors of a paper presented at an earlier date, Oklahoma could cut its first-year medical school slots by 10% next year and reach the goal of 185 physicians per 100,000 population by 1999. A 20% cut would reach this goal by 2007. However, we would again emphasize the potential fallacy and the techniques for arriving at this projected need.

Another area of intense concern to the Council is the present cost of physician manpower production. A comparison of national medical school expenditures in the school year 1958-59 to the school year 1982-83 indicates an increase from \$319 million to \$7 billion 65 million. It should be said, in all fairness, that figures are not adjusted for inflation. In the present milieu of reported fiscal crisis in our institutes of higher education, we must ask questions that society, government planners, and the medical profession itself should ask: "Can society afford this?" We think the answer is becoming fairly obvious.

Also of concern are the gross statistics for projected population for the State of Oklahoma. We are in no position to question the statistics supplied by the Oklahoma Employment Security Commission's projections; however, one wonders if these projections were made at a time of economic expansion in our state, when there was an influx of population due to energy-related industrial activities. We are all aware that this influx has significantly decreased in the last 2 to 3 years, and our feeling is that the population statistics will warrant very close scrutiny as we attempt to continue to monitor health professional needs.

We think it would be very easy to call for immediate drastic cuts in medical school enrollment, which has been done in several states and even in our own state by certain individuals. We think this is ill-advised. We think that a concerted effort to carry our socioeconomic research is needed to answer the questions: "How many physicians are optimal for a given segment of society, and what should the specialty and primary specialty mix for our society be? What is the impact of foreign-trained U.S. medical students? What should the licensing requirements be? What is the impact of female medical graduates, now numbering a third of the graduating class, on physician manpower pool?" These are questions that beg for an answer. They must be answered prior to precipitously calling for a marked reduction in the production of physicians.

Several state legislatures and Regents of Higher Education have mandated significant reductions in first-year medical school classes. *The Oklahoma State Medical Association Council on Medical Education recommends a 15% reduction in admissions to state-supported schools producing physicians.* The health care system and medical practice must respond to the forces which call for a decrease in physician production, but maintain the quality of physicians that the American people have come to expect. Medical practice effectiveness should be studied, and an assessment should be made of the outcomes of innovations in medical practice modes. We should attempt to design our educational process to meet these needs, and the growth rate of physician supply should be restrained, but in a way that will preserve the quality of both physicians and the educational institutions which provide these physicians. It should be restrained only to the point of providing the best health care possible for our patients, the citizens of the State of Oklahoma, and to society as a whole.

# Report of the COUNCIL ON MEDICAL SERVICES

Subject: **Annual Report**  
Presented by: John A. Blaschke, MD  
Referred to: Reference Committee II

## Introduction

The Council has been charged with the duties of studying and making decisions and formulating activities with respect to provisions of accurate medical care, including but not limited to the design of evaluation of all types of health care delivery systems, health planning, the financing of medical services and its impact on the quality of patient care, the social aspects of health, internal peer review mechanism, and the appraisal of all external programs which affect the cost and quality of medical care.

## Review of Activities

**A. Appropriateness Review Committee** — The Council continues to review cases when they deal with the quality or appropriateness of care. The Council has not done actual fee review for two years due to the decisions handed down by the United States Supreme Court and the Federal Trade Commission.

It was brought to our attention this year that some states are beginning to do modified fee review. We have contacted the legal department of the American Medical Association concerning this and have received no response.

Since May, 1984 the Council has reviewed approximately thirty cases.

**B. Physician Placement** — Still one of the most critical areas in the health planning arena is physician placement, getting doctors into the areas that need them.

The OSMA has no official placement program, but rather depends upon the efforts of the Physician Manpower Training Commission. The biggest problem confronting the PMTC is budget restraints of the state. We have lost no residency training slots, but our residents have not had a pay increase and we are losing ground with surrounding states.

OSMA members serving the PMTC are Billy Dotter, MD, Okeene; Francis Hollingsworth, MD, El Reno; and C.S. Lewis, Jr., MD, Tulsa. Others who continue to support the PMTC are medical staff and officials of the University of Oklahoma College of Medicine and Tulsa Branch.

**C. Additional Activities** — From time to time, certain projects are assigned to the Council because of their general nature. This occurred early last year when the OSMA was asked by the Oklahoma Pharmaceutical Association to assist them in trying to find ways to streamline the Vendor Drug Program for the State of Oklahoma Department of Human Services.

Faced with budget cuts, the Department decided to eliminate the Vendor Drug Program, which allows three free prescriptions per month, entirely if it could not be reduced. The Pharmaceutical Association was asked to work on the problem. We discussed several alternatives, but the only one the Department would accept was the following: The Department of Human Services, as purchaser of drugs for recipients of medical assistance benefits, authorizes the use of generic drug products for eligible Medicaid recipients. The committee also recommended a list of maximum allowable cost products and maximum cost prices to be used in Oklahoma.

The Vendor Drug Program Committee was representative of the Oklahoma Pharmaceutical Association, the OSMA, and the Oklahoma Osteopathic Association. OSMA members were Edgar W. Young, Jr., MD; James D. Funnell, MD; and Jerry B. Vannatta, MD. Thomas L. Whitsett, MD, also served on the committee.

## Recommendations

1. The Appropriateness Review Committee will continue its activities.
2. Continue support for the Physician Manpower Training Commission and its physician placement program.
3. The Council continue its liaison with allied health professional organizations.
4. The Council continues to send representatives to local, state and national education meetings.

## Budget Requests

Council meeting expenses	\$1,000.00
Education	1,000.00
Other Council objectives	1,000.00
Total	\$3,000.00



Respectfully submitted,  
John A. Blaschke, MD, Chairman  
Ronald S. Barlow, MD  
Donald L. Cooper, MD  
G. Kevin Donovan, MD  
Kurt Frantz, MD  
Jay A. Gregory, MD  
Bartis M. Kent, MD  
Gretchen A. McCoy, MD  
Ray V. McIntyre, MD  
John R. Perkins, MD  
Ed E. Rice, MD  
David J. Shepherd, Jr., MD  
Rick Ernest, OSMA Staff

## Report of the COUNCIL ON HOSPITAL MEDICAL STAFFS

Subject: **Annual Report**  
Presented by: Orange Welborn, MD  
Referred to: Reference Committee II

### Introduction

The Council shall provide a means to address the relationship between members of the OSMA and hospital medical staffs. It shall establish and maintain a communications liaison with organized hospital medical staffs, shall develop policy recommendations regarding medical staff relations for the consideration by the Association, and shall establish and maintain relations with federal and state government entities having statutory or regulatory jurisdiction affecting hospital medical staffs. The Council shall monitor and communicate to the OSMA the activities of the Hospital Staff Section of the American Medical Association.

### Review of Activities

The Council was created because of the tremendous interest by hospital medical staffs throughout the country and Oklahoma to have direct representation in the planning and activities of organized medicine.

The AMA opted to give the section on hospital medical staffs representation by allowing it one delegate and alternate. The OSMA has no mechanism for sections, so we created a council. We are still in the development stage of actually seeing where and how we can best serve the Association. We do know that we have created a channel for reaching a segment of our society that thoroughly covers the state, and so far we feel it has worked well.

The Council has had two meetings. The first was more of an organization function, but the second was to discuss the new Professional Review Organization regulations which caused so much controversy last fall. Because of our Council, we were able to basically put vital information into the hands of individuals who then went back to their own hospitals and communities to disseminate that information.

The Council was also utilized in notifying each hospital staff and administration of pending legislation and the response was excellent.

### Recommendations

1. The Council continue to identify and work in areas where it can be beneficial to the OSMA.
2. The concept of an Executive Committee continues to be explored.
3. OSMA continue its involvement with the AMA's Hospital Medical Staff Section.

### Budget Requests

Meeting expenses .....	\$2,000.00
Total .....	\$2,000.00

## Oklahoma Foundation for Peer Review, Inc. ANNUAL REPORT

The Oklahoma Foundation for Peer Review is proud to present its achievements through March 1985. The success of any effort is best measured in terms of progress toward stated objectives. OFPR's specific objectives are formally stated in our contract with the Health Care Financing Administration. A synopsis of them is included in this package for your convenience.

It is no coincidence that there are five quality objectives and three cost-conscious admission objectives. The Foundation is a physician sponsored organization that advocates and promotes the idea that all citizens of Oklahoma are entitled to the best possible quality medical care that can be rendered while at the same time helping ensure that these services are provided in the most cost effective manner.

During this last year the staff has been increased from 12 employees to over 52. In addition to writing the PRO contract bid and negotiating the contract to its finality, a totally new computer software and hardware system had to be programmed and installed and most of the management and review staff had to be relocated to larger quarters while implementing the PRO contract regulations before November 1, 1984.

### Charts 1 - 3

The first three charts in the report package illustrate that reductions are occurring.

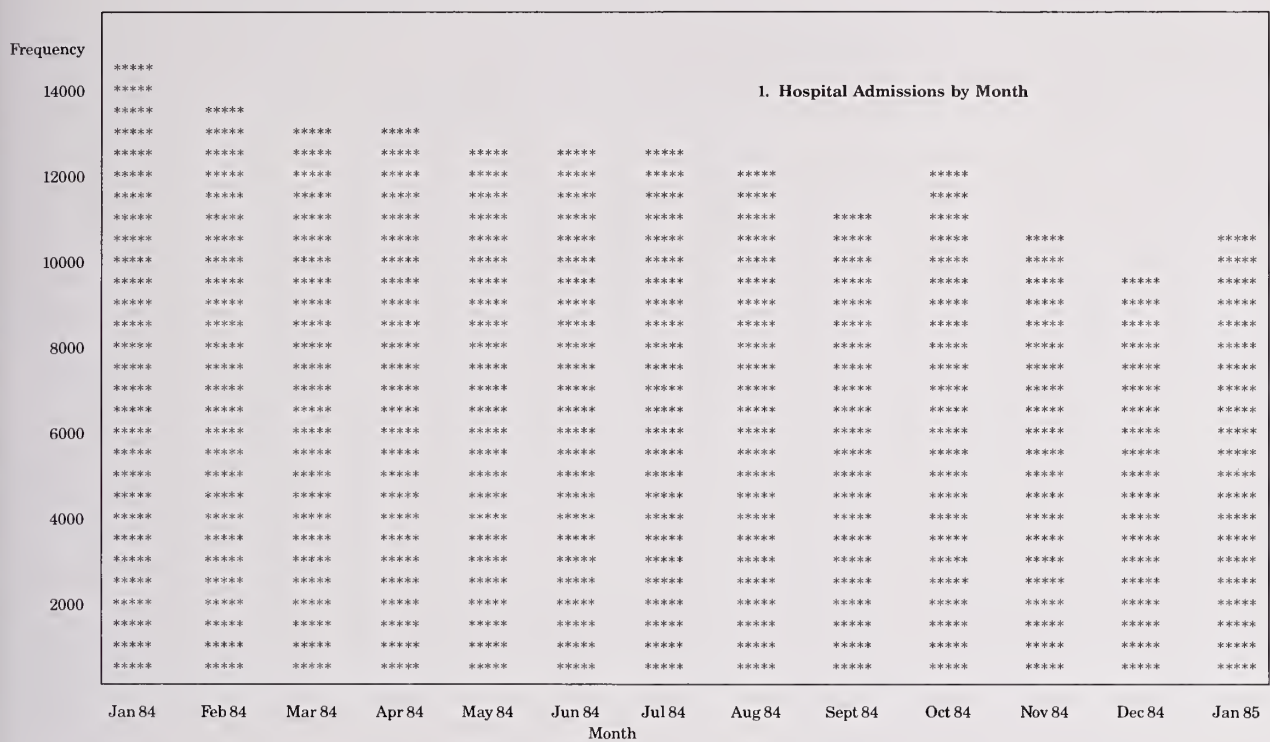
Chart 1 shows admission activity for a 13-month period. Because of normal fluctuations according to seasonal patterns, it is probably most significant to compare January 1984 admissions with those occurring in January 1985. The decrease is approximately 30%.

Chart 2 depicts the same data by quarter, a grouping which controls for seasonal variation to some extent. If February 1985 admissions fall below February 1984 by the same percentage as January 1985 versus January 1984, and if March 1985 decreases at the same rate, the first quarter of 1985 will have approximately 29,000 admissions when all the claims are in.

Chart 3 graphically displays the data group by quarters. A fifth bar reflecting projected data could be charted at about 29,000.

### Charts 4 - 6

Under normal circumstances five percent of claims filed are randomly selected for review by OFPR staff. One hundred percent of claims are reviewed for certain Diagnostic Related Groups and other specific problem areas. When



an admission does not meet "Blue Max" criteria, a copy of the complete medical file is referred to a physician advisor, who is a board certified or board eligible physician and has to be a practicing physician, for their decision as to whether to allow or deny the admission.

Chart 4 depicts the trend in denial rates, by quarter, since first quarter of 1984. Figures are based upon the quarter in which claims were reviewed. Thus, first quarter 1985 reflects admission activity that occurred in fourth quarter 1984. A comparison of first quarter 1985 against first quarter 1984 reflects the impact of OFPR efforts and with those of the physicians and hospitals throughout the state. The continuous downward trend through five quarters is, however, indicative of a long standing effort by OFPR staff members to be constructive and helpful. During the last 13 months over 150 meetings have been held, including Physician Advisor training, exit conferences, coding seminars, and countless less formal contacts.

If review of a hospital's claims for one quarter results in the denial of three cases (or 2.5% of their cases reviewed, whichever is greater), then 100% of that hospital's admissions will be reviewed for one subsequent quarter. Denials during that intensified review quarter may cause Medicare reimbursements to be recouped, depending on whether a hospital has retained its favorable waiver status. Chart 5 indicates that hospitals are on the right course, with an 88% decrease in denials since first quarter 1984.

The OFPR data system also stratifies claim denials by physician, in compliance with Admission Objective III. When a doctor has three claims (or 2.5% of his reviewed Medicare cases, whichever is larger) denied in one quarter, review of his cases is intensified by requiring all his admissions to be approved in advance during a subsequent quarter. This requirement, which began since the PRO contract

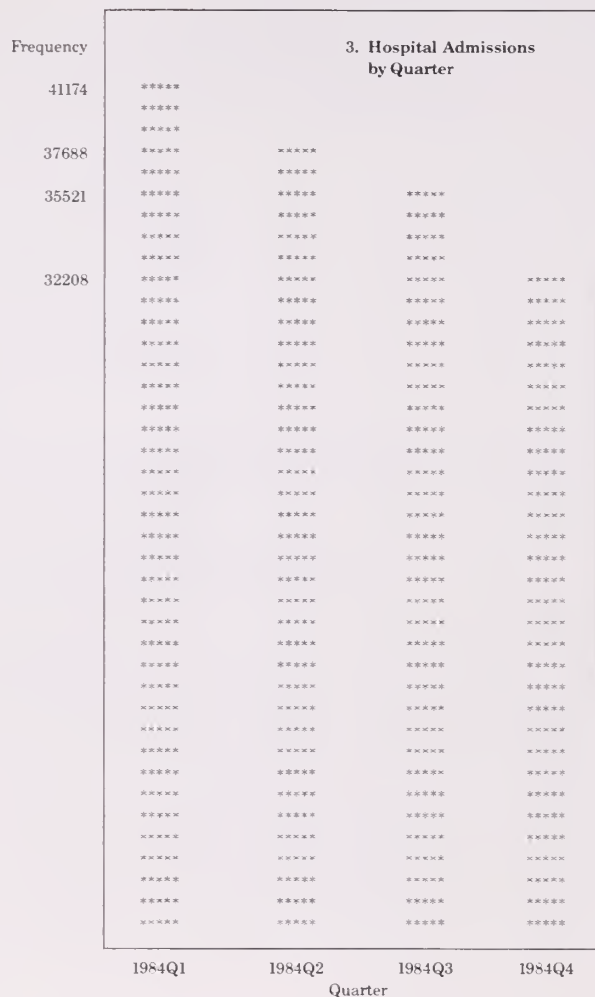
2. Hospital Admissions by Month			
Month	Frequency	Percent	Quarter Total
8401	14669	9.6	41,174
8402	13475	8.8	
8403	13030	8.5	
8404	12770	7.2	37,688
8405	12634	4.9	
8406	12284	6.3	
8407	12595	8.3	35,521
8408	12092	7.9	
8409	10834	7.1	
8410	11921	7.8	32,208
8411	10709	7.0	
8412	9578	6.3	

was awarded, was levied against 15 doctors during fourth quarter 1984. As illustrated in Chart 6 only two Oklahoma physicians are currently required to obtain preadmission certification during the months of May through July, 1985. That is a decrease of 87%, and it focuses upon fewer than 0.05% of the physicians in this state. That statistic obviously speaks well for the physician community. But we feel it also pays a compliment to OFPR's educational efforts and reflects our eagerness to work with the physicians as partners to achieve better health care for Medicare patients in Oklahoma.

#### Chart 7

One area with the potential for severe adverse impact upon patient care is premature discharges, which may result in a re-admission soon after. OFPR was required to





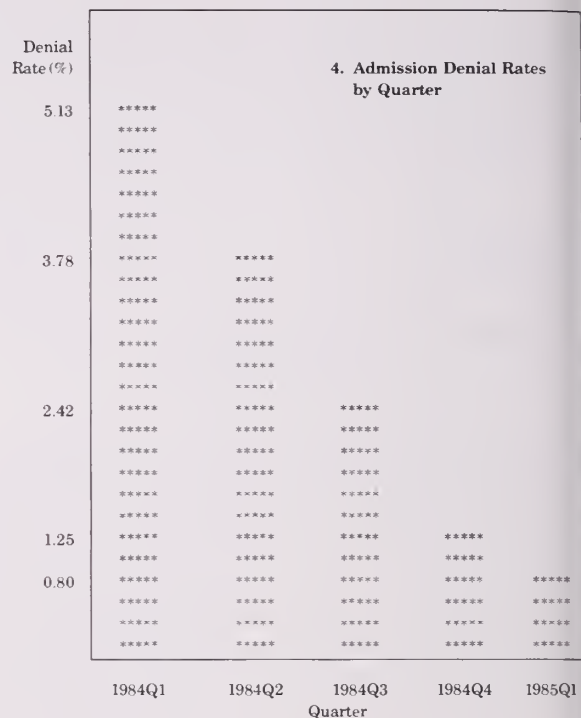
establish Quality Objective I and has inserted an edit in the data system to assure review of all readmissions within 10 days after a discharge. Chart 7 portrays the results — another vast improvement (a 17% reduction) since the first quarter under the new contract.

#### Chart 8

One of the new activities, stipulated in the PRO contract under Admission Object I and Quality Objective IV, begun in November 1984, is preadmission certification. Chart 8 reflects the number of such reviews performed each month through March 1985, for what objective. It is noteworthy that, as of March 29, 6,758 preadmission reviews had been performed. Of these, 6,735 (99.7%) were approved on the spot; 23 (9.3%) were referred to a physician advisor; of those only 11 (0.16%) were denied. These figures serve as a strong indication that the most sensitive aspect of the new PRO requirements is being implemented with a great deal less trauma than was feared.

#### Chart 9

Despite the requirement for preadmission certification in specified instances, some physicians do not consistently obtain approval in advance. One hundred percent of those cases are reviewed after admission. If it is determined that



a pattern by a physician exists of noncompliance for preadmission certification, the OFPR will begin educational efforts detailing the importance of compliance in preadmission certification to that physician. At the same time, this physician's ID number will be given to the Fiscal Intermediary and all of his claims will be flagged and suspended for payment pending review by the OFPR.

If a pattern of noncompliance by the identified physician persists despite educational efforts of the OFPR, sanction recommendations will be made to the HCFA Regional Office.

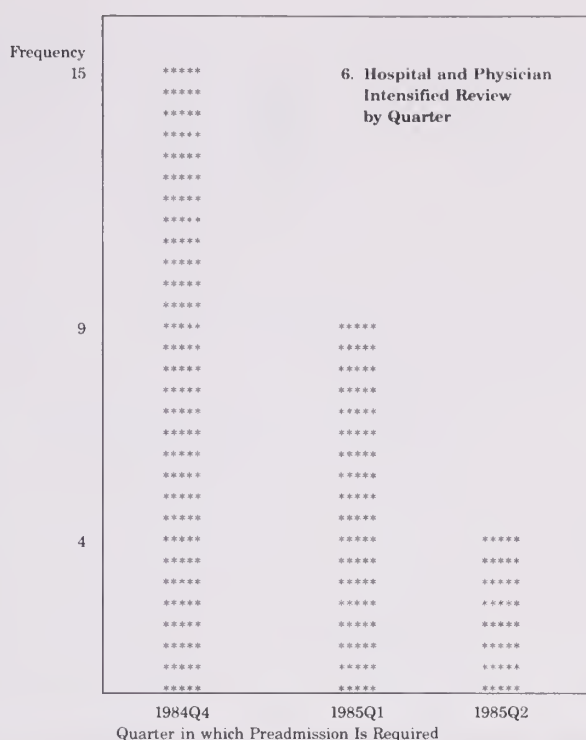
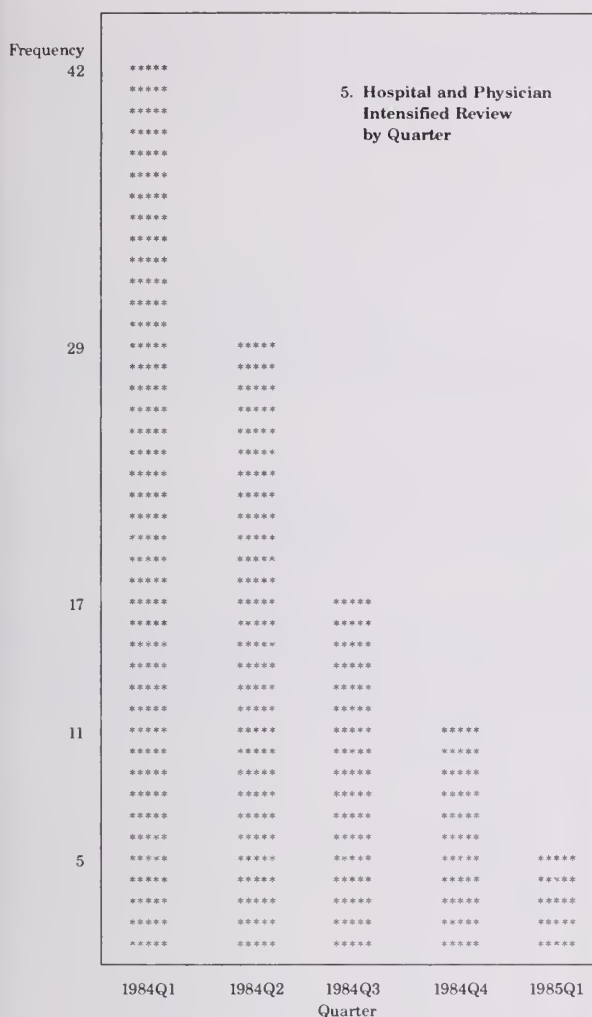
As of March 29, there had been 1,443 such cases. Of that number, 1,407 were retrospectively approved by an OFPR review coordinator; 36 were referred to physician advisors; and 27 of the 36 were approved.

Five percent of all cases receiving preadmission certification are randomly selected for retrospective review as well. In this process only one case needed to be referred to a physician advisor because the record failed to substantiate the preadmission information furnished OFPR. That case was approved by the physician advisor.

The nine physicians on intensified review during the first quarter of 1985 as a group called in a total of only 73 requests for preadmission certification. Yet they admitted at least 233 patients (not all claims are in). Of the requests called in, however, 62 (85%) were approved on the spot; 11 (15%) were referred to a physician advisor and 10 of those (14%) were approved.

#### Chart 10

The final chart depicts problem areas found during reviews for quality objectives. Review of these cases in accordance with Quality Objective III revealed only five so far which needed referral for higher level review. As of the end of March, 17 were in Level I review, another four were in



On their way to the House of Delegates are Victor L. Robards, MD, (left) Tulsa, AMA delegate, and Jack Spears, executive director of the Tulsa County Medical Society.

Level II, and only one was in Level III review.

During review of these cases, problems of quality were discovered in six cases that involved multiple transfers of patients.

Reviews performed under the auspices of Quality Objectives II (Inappropriate Antimicrobials) and V (Post Operative and Other Complications) a total of 33 records revealed actual quality problems having to do with either Mosocoma infections and/or inappropriate antibiotic usage.

An assortment of other significant indications is listed as item III of this chart. This data is strongly indicative of the OFPR commitment to quality as well as cost-effectiveness.

## Conclusion

As can be seen, the objectives stated in the Foundation's contract with HCFA are being met. In addition we are encouraged by the continuous improvements recorded for physicians and hospital personnel as well as our own staff. We all know that problems remain. However, our achievements to date offer proof that, working together, we can maintain the favorable trend. We can, through partnership, deliver high quality medical care in an ethical, but cost-conscious, manner.



## 7. Premature Discharges by Quarter

Quarter		Total Premature Discharges	Total Reviewed Discharges
1984Q3	*****	58	14,650
1984Q4	*****	484	19,206
1985Q1	*****	279	15,915
	0.40 1.75 2.52		
	Percent		

## 8. Pre-Admission Reviews

<b>November, 1984</b>		
Admission Objective I	—	286
Quality Objective IV	—	624
Phone Handled	—	341
Mail Handled	—	569
Total Procedures	—	910
<b>December, 1984</b>		
Admission Objective I	—	496
Quality Objective IV	—	852
Phone Handled	—	903
Mail Handled	—	445
Total Procedures	—	1348
Total Cases	—	1086
<b>January, 1985</b>		
Admission Objective I	—	751
Quality Objective IV	—	1211
Phone Handled	—	1341
Mail Handled	—	621
Total Procedures	—	1962
Total Cases	—	1373
<b>February, 1985</b>		
Admission Objective I	—	657
Quality Objective IV	—	942
Phone Handled	—	957
Mail Handled	—	139
Total Procedures	—	1599
Total Cases	—	1227
<b>March, 1985</b>		
Admission Objective I	—	795
Quality Objective IV	—	1097
Phone Handled	—	1437
Mail Handled	—	455
Total Procedures	—	1892
Total Cases	—	1426
<b>As of March 29, 1985</b>		
Total Referrals	—	23
Total Denials	—	11

## Synopsis of Objectives

### Oklahoma Objective Summary

**Admission Objective Area I** — Reduce admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting or on an outpatient basis.

#### Objective Statement.

Reduce by seventy-seven percent (77%) or twenty-four thousand eight hundred eighty-one (24,881) admissions for 183 surgical procedures that could safely and appropriately be performed as outpatient procedures.

#### Sub-objective A:

Reduce by one hundred percent (100%) or seventeen thousand seven hundred forty-eight (17,748) admissions for one-to-three-day stays where one or more outpatient procedures are performed.

#### Sub-objective B:

Reduce by fifty percent (50%) or seven thousand one hundred thirty-three (7,133) admissions where one or more outpatient procedures are performed. This figure is derived by taking projected admissions without intervention (32,014) and subtracting the projected reductions addressed in Sub-objective A (17,748). The remaining fourteen thousand two hundred sixty-six (14,266) admissions will be reduced by fifty percent (50%).

### Procedures Which May Be Performed On An Outpatient Basis

02.95	Removal of Halo Device
03.31	Shunt Trap
03.92	Interspinous Ligament Epidural Steroid Injections
04.07	Infraorbital Neurectomy Supraorbital Neurectomy
04.43	Carpal Tunnel Release
04.6	Ulnar Nerve Transposition
04.79	Other Neuroplasty
04.81	Peripheral Nerve Blocks
05.31	Root Blocks
08.21	Chalazion Removal (Excision, Vision, Eyelid) NOS
08.22	Plantar Wart Excision
08.31	Repair Blepharoptosis by Frontalis Muscle Tech w suture
08.33	Repair Blepharoptosis by Resec or Adv. Levator or Aponeurosis
08.34	Repair Blepharoptosis by Other Levator Muscle Techniques
08.35	Repair of Blepharoptosis by Tarsal Technique
08.36	Repair Blepharoptosis by Other Techniques
08.38	Correction of Lid Retraction
08.42	Repair Entropion Ectropion by Suture Technique
08.43	Repair of Entropion Ectropion w Wedge Resection
08.44	Repair Entropion Ectropion with Lid Reconstruction
08.49	Other Repair of Entropion or Ectropion
08.52	Tarsorrhaphy
08.59	Canthoplasty
08.70	Reconstruction of Eyelid, NOS
09.42	Probing of Lacrimal Canaliculi
11.31	Transposition of Pterygium
11.32	Excision of Pterygium with Corneal Graft
11.39	Other Excision of Pterygium
13.19	Intracapsular Extraction of Lens — Other
13.41	Phacoemulsification and Aspiration of Cataract
13.59	Extracapsular Extraction of Lens — Other
13.61	Dissection of Primary Membranous Cataract
13.64	Dissection of Secondary Membranous Cataract
13.65	Excision of Secondary Membrane (After Cataract) Capsulectomy
13.66	Mechanical Fragmentation of Secondary Membrane
13.69	Other Cataract Extraction
13.71	Insertion of Intraocular Lens Prosthesis at Cataract Extraction
15.11	Recession of One Extraocular Muscle
15.3	Operation on 2 or More Extraocular Muscles w Globe Detach
18.29	Preauricular Pits and Tags
21.03	Nasal Cautey
21.31	Nasal Polypectomy
21.71	Closed Reduction Fracture Nose
23.09	Tooth Extraction Nec
23.19	Surgical Extraction of Tooth
24.5	Alveoloplasty
29.11	Nasopharyngoscopy for Velopharyngeal Closure Mechanism
31.42	Laryngoscopy
33.23	Bronchoscopy

## 9. Pre-Admission Reviews

Pre-admission cases without pre-admission authorization by OFPR — 100% reviewed retrospectively: total cases = 1443

### P.A. Referrals

January - 4	Approved - 2	Denied - 2
February - 4	Approved - 3	Denied - 1
March - 28	Approved - 22	Denied - 5

Preadmission requests approved but when reviewed retrospectively referred:

November - 1 (Case approved by Physician Advisor)

Pre-admission requests by Focused Physicians for January - March, 1985:

### Requests called into OFPR

#1104980---- 0  
 #1105626---- 0  
 #1106591---- 26  
 #1106791---- 2  
 #1106919---- 34  
 #1108068---- 2  
 #1202050---- 9

### Inpatient Medicare Admissions by focused physician - for January, February, and March

10  
 0 (Died of Cancer)  
 74  
 55  
 94  
 Not Available  
 Not Available

Pre-admission requests for focused physicians referred to Physician Advisor - 11

APPROVED - 10  
 Denied - 01

## 10. Pre-Admission Reviews Quality Objectives Report

I. Multiple transfers with quality problems - 6 records

II. Nosocomial infections/inappropriate antibiotic usage - 33 records

III. Quality Review: Avoidable Death Reviews

Name	Hospital	Review Level
E.B.	St. Francis	II
G.S.	Marlow	II
H.B.	Marlow	II
N.L.	Nowata	II
P.H.	St. Joseph	III

Referrals: Week 03/25 to Level I review - 17 records

IV. Quality problems within hospitals:

One (1) hospital with adverse decisions on inappropriate drug usage, adverse fluid therapy, questionable diagnosis and treatment - twelve (12) records (one physician)

One (1) hospital with twenty-nine (29) records reviewed, twenty-eight (28) patients received the same antibiotic.

One (1) hospital with one (1) patient who was readmitted and transferred as a result of adverse patient teaching.

One (1) hospital requested review of a patient admitted from a nursing home with multiple lacerations, anemia, and dehydration.

78.63 Removal of Internal Fixation Device Radius and Ulna  
 78.64 Removal of Internal Fixation Device Carpals and Metacarpals  
 78.65 Removal of Internal Fixation Device — Femur  
 78.66 Removal of Internal Fixation Device — Patella

33.26 Percutaneous (Needle) Biopsy of Lung  
 33.27 Other Biopsy of Lung  
 34.24 Pleural Biopsy  
 38.21 Biopsy of Blood Vessel  
 40.11 Lymphatic Biopsy  
 41.31 Biopsy of Bone Marrow  
 42.23 Esophagoscopy, w/o Procedure  
 44.13 Gastroscopy  
 45.13 Other Endoscopy of Small Intestine  
 45.23 Diagnostic Colonoscopy  
 45.24 Other Endoscopy of Large Intestine  
 48.23 Proctosigmoidoscopy  
 48.35 Local Excision of Rectal Lesion or Tissue  
 49.12 Anal Fistulectomy  
 49.3 Local Excision or Destruction of Other Lesion or Anus Tissue  
 49.46 Excision of Hemorrhoids  
 49.51 Left Lateral Anal Sphincterotomy  
 49.59 Other Anal Sphincterotomy  
 53.00 Unilateral Repair of Inguinal Hernia Not Specified  
 54.21 Laparoscopy, Peritoneoscopy  
 55.92 Renal Cyst Puncture  
 56.1 Ureteral Meatotomy  
 57.32 Other Cystoscopy  
 57.33 Transurethral Biopsy of Bladder  
 57.34 Small Bladder Biopsy  
 57.49 Other Transurethral Excision/Destruction of Bladder Tissue  
 57.95 Catheter Change, Suprapubic or Urethral  
 58.1 Urethral Meatotomy  
 58.22 Other Urethroscopy  
 58.3 Excision/Destruction of Urethral Tissue or Lesion  
 58.6 Dilation of Urethra  
 60.11 Needle Biopsy of Prostate  
 61.91 Percutaneous Aspiration of Tunica Vaginalis  
 63.1 Excision of Varicocele & Hydrocele of Spermatic Cord  
 63.73 Vasectomy  
 64.0 Circumcision  
 67.12 Other Cervical Biopsy  
 67.39 Other Excision or Destruction of Lesion or Tissue of Cervix  
 68.12 Hysteroscopy  
 69.09 Other Dilation and Curettage  
 70.21 Colposcopy  
 71.22 Incision of Bartholin's Gland  
 71.3 Other Local Excision or Destruction of Vulva & Perineum  
 77.40 Biopsy of Bone, Unspecified Site  
 77.49 Biopsy of Bone, Pelvic Bones, Phalanges, Vertebrae  
 77.59 Exostosis: Superficial, Distal (Other Bunionectomy)  
 78.60 Removal of Internal Fixation Device Unspecified Site  
 78.61 Removal of Internal Fixation Device Scapula/Clavicle/Thorax  
 78.62 Removal of Internal Fixation Device Humerus



78.67 Removal of Internal Fixation/Device Tibia and Fibula  
 78.68 Removal of Internal Fixation/Device Tarsals and Metatarsals  
 78.69 Removal of Internal Fixation/Device Other  
 79.00 Closed Reduction of Fracture W/O Internal Fixation/Unspecified  
 79.01 Closed Reduction of FX W/O Internal Fixation Humerus  
 79.02 Closed Red of FX W/O Internal Fixation Radius and Ulna  
 79.03 Closed Red of FX W/O Internal Fixation Carpals and Metacarpals  
 79.06 Closed Red of FX W/O Internal Fixation Tibia and Fibula  
 79.07 Closed Red of FX W/O Internal Fixation Tarsals and Metatarsals  
 79.09 Closed Red of FX W/O Internal Fixation/Other Specified Bone  
 79.71 Closed Reduction of Dislocation of Shoulder  
 79.72 Closed Reduction of Dislocation of Elbow  
 79.73 Closed Reduction of Dislocation of Wrist  
 79.76 Closed Reduction of Dislocation of Knee  
 79.77 Closed Reduction of Dislocation of Ankle  
 79.78 Closed Reduction of Dislocation of Foot and Toe  
 80.20 Arthroscopy, Unspecified Site  
 80.25 Arthroscopy, Hip  
 80.26 Arthroscopy, Knee  
 80.74 Synovectomy — Hand  
 81.18 Arthrodesis of Foot and Ankle/Other Fusion of Toe  
 81.92 Injection of Therapeutic/Substance into Joint/Ligament  
 82.09 Other Incision of Soft Tissue of Hand  
 82.11 Tenotomy of Hand/Tendon Release of Hand  
 82.21 Ganglion, Superficial  
 82.33 Other Tenonectomy of Hand  
 82.86 Other Tenoplasty of Hand  
 83.09 Other Incision of Soft Tissue  
 83.13 Division of Muscle, Tendon & Fascia/Other Tenotomy  
 83.21 Uncomplicated Muscle Biopsy/Biopsy of Soft Tissue  
 83.32 Mucocele Excision/Not Requiring Grafting  
 83.42 Tenotomy, Hand or Foot  
 83.88 Extensor Tendon Repair, Single  
 83.96 Bursa  
 84.11 Amputation of Lower Limb/Amputation of Toe  
 85.11 Percutaneous (Needle) Biopsy of Breast  
 85.12 Other Biopsy of Breast  
 86.04 Other Incision with Drainage of Skin and Subcutaneous Tissue  
 86.05 Incision with Removal of Foreign Body from Skin: Subcutaneous  
 86.11 Biopsy/Skin and Subcutaneous Tissue  
 86.22 Debridement of Wound, Infection, or Burn  
 86.23 Excision: Fingernail, Toenail  
 86.3 Epidermoid Cyst Excision  
 86.60 Free Skin Graft, Not Otherwise Specified  
 86.61 Full-Thickness Skin Graft to Hand  
 86.62 Other Skin Graft to Hand  
 86.63 Full-Thickness Skin Graft to Other Sites  
 86.66 Homograft to Skin  
 86.69 Other Skin Graft to Other Site  
 87.09 Other Soft Tissue X-ray — Face, Hand and Neck  
 87.54 Other Cholangiogram  
 87.69 Air Contrast Intestinal Studies  
 87.74 Retrograde Pyelogram  
 87.76 Retrograde Urethrogram  
 87.77 Cystograms (Including Voiding)  
 87.79 Urodynamic Studies  
 88.32 Arthrogram: Hip—Shoulder—Knee  
 88.72 Diagnostic Ultrasound of Heart  
 88.74 Diagnostic Ultrasound of Digestive System  
 88.76 Diagnostic Ultrasound of Abdomen and Retroperitoneum  
 88.89 Thermography of Other Sites  
 89.14 Routine EEG — Average Evoked Response  
 89.22 Cystometrogram  
 89.29 Calibration of Urethra  
 92.15 Pulmonary Scan  
 93.08 EMG  
 93.29 Other Forcible Correction of Deformity  
 96.49 Bladder Instillation  
 97.11 Replacement of Cast Upper Limb  
 97.12 Replacement of Cast Lower Limb  
 97.33 Removal of Dental Wires  
 97.83 Removal of Abdominal Wall Sutures  
 97.89 Removal of Other Therapeutic Device  
 98.20 Removal of Foreign Body, Not Otherwise Specified  
 98.28 Removal of Foreign Body from Foot W/O Incision  
 99.17 Injection of Insulin  
 99.21 Injection of Antibiotic  
 99.23 Injection of Steroid  
 99.25 Injection/Infusion of Cancer/Chemotherapeutic Substance—NEC  
 99.29 Injection/Infusion of Other Therapeutic/Prophylactic Sub.

#### Validation:

The Oklahoma Foundation for Peer Review identified, in calendar year 1983, eighteen thousand seven hundred thirteen (18,713) admissions in which the principal procedure was one of 183 listed in the Objective Statement. Within the eighteen thousand seven hundred thirteen (18,713) admissions, sixteen thousand seven (16,007) admissions were identified in which up to three (3) procedures were performed, all of which were found on the outpatient procedure list. For example, a patient could have a lens extraction, a lens implant, and a nasal polypectomy, but he could not have a lens extraction and a cholecystectomy performed on the same admission.

Within the sixteen thousand seven (16,007) admissions, eight thousand eight hundred seventy-four (8,874) cases were isolated in which up to three outpatient procedures were performed and the lengths of stay were three (3) days or less. Based on this data, the Foundation feels that a one hundred percent (100%) reduction of admissions can be achieved for cases that would require a length of stay not exceeding three (3) days and where up to three (3) outpatient procedures would be performed.

With education and intervention, the Foundation is projecting an impact of a fifty percent (50%) reduction in the remaining admissions in which up to three (3) outpatient procedures would be performed, eliminating the one-to-three-day length of stay parameter.

#### Primary Methodology:

The Foundation will perform one hundred percent (100%) pre-admission review on cases in which the physician plans to perform one of the 183 surgical procedures listed in the Objective Statement. The Foundation's Preadmission Review Coordinator will approve the admission if appropriate criteria is met. If criteria is not met, the Medical Director will discuss the case with the attending physician and will then either approve or deny the admission.

On a quarterly basis, profiles by hospital and physician and procedure will be generated in order to identify problem areas. Intervention will occur through provider education, waiver rebuttal and sanction recommendations.

**Admission Objective Area II** — Reduce the number of inappropriate or unnecessary admissions or invasive procedures for specific diagnosis related groups (DRGs).

#### Objective Statement:

Reduce by fifty percent (50%) or six thousand seven hundred twenty-eight (6,728) the number of inappropriate Medicare admissions grouping to one of the following thirty-one (31) DRGs:

DRG	NARRATIVE
15	Transient Ischemic Attacks
18	Cranial & Peripheral Nerve Disorders greater than or equal to 70 and/or C.C.
24	Seizure & Headache Age greater than or equal to 70 and/or C.C.
65	Dyssequilibrium
68	Otitis Media & URI Age greater than or equal to 70 and/or C.C.
88	Chronic Obstructive Pulmonary Disease
101	Other Respiratory Diagnoses Age greater than or equal to 70 and/or C.C.
132	Atherosclerosis Age greater than or equal to 70 and/or C.C.
134	Hypertension
177	Uncomplicated Peptic Ulcer greater than or equal to 70 and/or C.C.
180	G.I. Obstruction Age greater than or equal to 70 and/or C.C.
182	Esophagitis, Gastroent. & Misc. Digest. Dis Age greater than or equal to 70 and/or C.C.
183	Esophagitis, Gastroent. & Misc. Digest Dis Age 18-69 W/O C.C.
189	Other Digestive System Diagnoses Age 18-69 W/O C.C.
203	Malignancy of Hepatobiliary System or Pancreas
205	Disorders of Liver exc Malig, Cirr, Alc Hepa Age greater than or equal to 70 and/or C.C.
207	Disorders of the Biliary Tract Age greater than or equal to 70 and/or C.C.
243	Medical Back Problems
244	Bone Diseases & Septic Arthropathy Age greater than or equal to 70 and/or C.C.
247	Signs & Symptoms of Musculoskeletal System & Conn Tissue
253	Fx, Sprns, Strns & Disl of Uparm, Lowleg Ex Foot Age greater than or equal to 70 and/or C.C.
280	Trauma to the Skin, Subcut Tiss & Breast Age greater than or equal to 70 and/or C.C.
294	Diabetes Age greater than or equal to 36
296	Nutritional & Misc. Metabolic Disorders Age greater than or equal to 70 and/or C.C.
320	Kidney & Urinary Tract Infections Age greater than or equal to 70 and/or C.C.
325	Kidney & Urinary Tract Signs & Symptoms Age greater than or equal to 70 and/or C.C.
331	Other Kidney & Urinary Tract Diagnoses Age greater than or equal to 70 and/or C.C.

**Admission Objective Area III** — Reduce the number of inappropriate or unnecessary admissions or invasive procedures by specific practitioners or in specific hospitals.

#### Objective Statement:

Reduce by eighty percent (80%) or three thousand five hundred fifty-two (3,552) the number of Medicare admissions for specific physicians with three (3) or more denials per quarter.

#### Validation:

The Foundation generated physician- and hospital-specific data for PPS reviews conducted from October 1, 1983 through March 31, 1984. These profiles identified four hundred (400) physicians with at least one admission denial at a PPS hospital. The profile isolated fifteen (15) physicians that had three (3) or more denials during the six-month period. These fifteen (15) physicians practiced at twenty-six (26) of the one hundred thirty-four (134) hospitals on PPS reimbursement.

The fifteen (15) physicians in the initial survey had a total of four hundred forty-four (444) admission denials for the survey period, which if projected over the two-year contract period would be eight hundred eighty-eight (888). Because this denial rate was based on only twenty percent (20%) of the hospitals on PPS, the denial rate projected over two years would be four thousand four hundred forty (4,440). The O.F.P.R. will reduce this number by eighty percent (80%) or three thousand five hundred fifty-two (3,552) admissions.



In the exhibit hall, Otie Ann Carr (left), OSMA associate director and lobbyist at the state legislature, discusses key issues with delegates.

#### Primary Methodology:

The Foundation will perform one hundred percent (100%) pre-admission/pre-payment review on any physician who meets or exceeds the three-case or 2.5% denial rate in the preceding quarter. The *Blue Max Criteria Set* will be utilized to determine the appropriateness of the admission. Quarterly analysis will be performed on hospital- and physician-specific profiles to identify physicians to be added to the list of those being monitored. A physician will be deleted from one hundred percent (100%) review when his denial rate for a quarter falls below the three-case or 2.5% threshold.

Intervention strategies will include individual training and educational sessions with aberrant providers, waiver rebuttal and sanction recommendations.

**Quality Objective Area I** — Reduce unnecessary hospital readmissions resulting from substandard care provided during the prior admission.

#### Objective Statement:

Reduce 867 unnecessary hospital readmissions resulting from substandard care provided during the prior admissions, readmissions with 10 days from complications, or incomplete management of problems in the previous hospitalization.

#### Validation:

Problem validation was accomplished by a readmission review program done on all readmissions within 7 days of discharge, beginning October 1, 1983. Review findings noted that 18% of readmissions were due to premature discharge. Also noted was a trend to readmit patients on the 8th, 9th, and 10th day following discharge after readmission review began. Therefore, review for this objective was increased to 10 days.

#### Primary Methodology:

Review of all discharges involving readmissions (both records) continues. Monthly data profile analyses are utilized to track this objective. Review results are being profiled by hospital, area, and physician. Remedial action and continuing medical education will be attempted to modify physician performance. Remedial action will include concurrent prior discharge approval. If these interventions are not successful, sanction will be instituted.

**Quality Objective Area II** — Assure the provision of medical services which, when not performed, have "significant potential" for causing "serious patient complications".

#### Objective Statement:

Assure a reduction of 13,318 cases in the use of inappropriate antimicrobials due to:

- a. Culture and sensitivity studies not performed, and
- b. Due to physicians' failure to comply with the results of sensitivity studies when these have been performed.

#### Validation:

Validation was done by means of a study on antimicrobial therapy, performed by the Oklahoma Foundation for Peer Review during 1983. The study was done on 4,012 cases in 87 hospitals, and established that 28% of patients who received antimicrobials for treatment of infection had no C&S Study performed. In addition, 17% of patients who did receive C&S Studies still received antimicrobials, for which the infectious organism was shown to be resistant.

#### Primary Methodology:

Review criteria will be applied to all cases under PPS Review in which the patient received antimicrobials to treat infection. Prophylactic use will be omitted from this review. Monthly profiles by hospital and physician will be analyzed, and trends will be identified. Intervention will begin with educational efforts for those physicians and hospitals involved; second stage intervention will be a 100% focused review of physicians involved, leading to sanction if the previous interventions are unsuccessful.

**Quality Objective Area III** — Reduce avoidable deaths.

#### Objective Statement:

Reduce by 90 cases avoidable deaths for DRG 014 (Cerebrovascular Disorders), and DRG's 121-125, and 138-139 (Cardiovascular Disorders).



#### Validation:

a. The Oklahoma Foundation for Peer Review conducted pattern analysis on all DRGs, and found that the above DRGs had an overall mortality rate of 14%. Of particular interest were DRG 014 (Mortality = 15%) and DRG's 121-123 (Mortality = 28%).

b. Specific study by OFPR physician advisors of sixteen cardiovascular death charts indicated that 18.75% (3 patients) were misdiagnosed, and 27.7% (5 patients) did not receive treatment which corresponded to the charted diagnosis. Coding errors and principal diagnosis identification errors were ruled out.

#### Primary Methodology:

Review of all deaths in these DRGs will be initiated, and review will be performed monthly. Review will utilize approved criteria. Cases not meeting criteria will be referred to a physician advisor for review. Any physician having a case where death is judged "avoidable" will be subjected to 100% review of all cases in these DRGs for the period of one calendar year. Educational efforts will be made at this time. If these efforts are successful, 100% review will terminate. If interventions are unsuccessful, the physician will be sanctioned.

#### Quality Objective Area IV — Reduce unnecessary surgery or other invasive procedures.

##### Objective Statement:

Reduce admissions for unnecessary surgery or other invasive procedures by 2,631.

The targeted procedures are:

DRG 310	Diagnostic Cystoscopy
DRG 311	Transurethral Excision Bladder Mass
DRGs 336-337	Transurethral Prostatectomy
DRGs 195-198	Cholecystectomy
DRG 209	Major Joint Replacement
DRGs 161-162	Inguinal/Femoral Hernia Repair
DRG 225	Foot Procedures

##### Validation:

The above procedure list was developed by comparative analysis of incidence rates, tissue study (cholecystectomy), and procedure justification audits (major joint replacement).

##### Primary Methodology:

Pre-admission/pre-procedure review will be conducted on 100% of elective and urgent cases requiring the above procedures. Retrospective pre-payment review will be conducted on emergency procedures. Non-emergency procedures done without pre-admission review will be denied. Aberrant patterns will be identified by physician and hospital after one quarter of review. Interventions will include educational efforts, then 100% pre-admission review of all procedures by targeted physicians, and ultimately physician sanction if the previous interventions fail.

#### Quality Objective Area V — Reduce avoidable postoperative or other complications.

##### Objective Statement:

Reduce by 1,080 cases the incidence of avoidable complications in hospitalized Medicare patients.

Part A: Reduce the incidence of avoidable postoperative complications in hospitalized Medicare patients.

Part B: Reduce the incidence of avoidable medical complications in hospitalized Medicare Patients.

##### Validation:

Problem identification was validated by two methods:

a. 1983 data revealed that 26.3% of all surgical patients, and 3.57% of medical patients had complicating comorbidities.

b. Quality surveys performed in 25 hospitals during January through May, 1984, showed that only four hospitals had infection control programs; only one hospital had a risk management program, and only one hospital reviewed the quality of anesthesia care.

##### Primary Methodology:

Occurrence screening criteria will be applied to all cases reviewed, including outliers. Monthly data profiles will be analyzed by physician and hospital for 16 high-risk areas. Aberrant providers will be targeted after the first quarter for focused review, consisting of 100% retrospective pre-payment monitoring in the target area, and educational intervention will begin. After one quarter of 100% review and educational intervention, if complications decrease significantly, 100% review will terminate. If, however, 100% review and educational intervention are not successful, sanction recommendations will follow.

##### DRG NARRATIVE

425	Acute Adjust React & Disturbances of Psychosocial Dysfunction
426	Depressive Neuroses
429	Organic Disturbances & Mental Retardation
449	Toxic Effects of Drugs Age greater than or equal to 70 and/or C.C.

##### Validation:

During calendar year 1983, the Foundation identified forty-eight thousand sixty-three (48,063) admissions that grouped to one to the thirty-one (31) DRGs listed in the Objective Statement. Based on retrospective PPS reviews from October 1, 1983 through April 30, 1984, each of the thirty-one (31) DRG categories had either a three (3) case or five percent (5%) admission denial rate. The average denial rate for the thirty-one (31) DRGs was fourteen percent (14%).

Based on the estimated number of admissions without intervention for one of the thirty-one (31) DRGs (92,126) and if fourteen percent (14%) are considered inappropriate, the Foundation projects a fifty percent (50%) reduction of inappropriate admissions for a total of six thousand seven hundred twenty-eight (6,728).

##### Primary Methodology:

The Foundation, working in conjunction with the Fiscal Intermediaries in Oklahoma, will perform one hundred percent (100%) retrospective prepayment review on any case in which the principal diagnosis groups to one of the thirty-one (31) DRGs in the Objective Statement.

The Foundation will review the case for the appropriateness of the admission using the approved *Blue Max Criteria*. Approval and denial decisions will be immediately sent to the Fiscal Intermediaries and reimbursement will be handled accordingly.

On a quarterly basis, hospital and physician profiles will be generated in order to identify problem areas. Interventions will include provider education, waiver rebuttal and sanction recommendations.

## Report of the AD HOC COMMITTEE ON OSMA / OFPR RELATIONS

### Subject: Special Committee Report

Presented by: John A. McIntyre, MD, Chairman

Referred to: Reference Committee II

The Oklahoma Foundation for Peer Review was incorporated as a non-profit organization in December of 1975 by the Oklahoma State Medical Association. The original Board of Directors consisted of 18 physicians of which four were DOs, and eight ex-officio members who were specific representatives of the medical and osteopathic associations. The corporation was organized specifically for the purpose of peer review and related activities and "To assume responsibilities for the duties and functions of Professional Standards Review Organizations as specified in Title XI, Part B of the Social Security Act . . ."

Federally mandated peer review has always been controversial with Oklahoma physicians. Since the introduction of the PSRO Law in 1969, the OSMA has opposed the law and its subsequent amendments. Oklahoma's congressional delegation largely supported the efforts of Oklahoma physicians but, nonetheless, the law was enacted in 1972 with an implementation date of January 1, 1974. During the legislative battles that led to the law's passage and even afterwards, OSMA Delegates to the AMA worked through the political machinery of the AMA to secure a strong national policy against PSRO. However, it became apparent that there was not sufficient public and legislative support for outright repeal of the law. Consequently, AMA adopted a position of modification and drafted a series of amendments to make the law more palatable.

Meanwhile the OSMA, following a mail plebiscite of the membership in May of 1973, instructed OFPR:

"The Oklahoma Foundation for Peer Review should be activated to undertake preliminary investigation of the PSRO Law and the forthcoming regulations, with the final decision to apply for PSRO involvement remaining vested with the OSMA House of Delegates."

OSMA made a loan of \$5,000 to OFPR to begin its investigation.

The OSMA House of Delegates, in a special called session on April 6, 1974, after reviewing a feasibility study on PSRO in Oklahoma, took the following action:



"We move that the OSMA House of Delegates delegate to the Board of Trustees the authority to allow the Oklahoma Foundation for Peer Review when and if, in the judgment of the Board of Trustees, this should be done, and that the current report of the OFPR be approved, and that the OSMA Board of Trustees be authorized to continue diligent work to repeal PSRO." (OSMA JOURNAL, Vol. 65, May 1974, p 219)

Before the PSRO plan could be developed and implemented, the then Secretary of the Department of Health, Education and Welfare, Casper Weinberger, caused to be published in the *Federal Register* regulations that required intensive concurrent review of all Medicare and Medicaid hospital admissions. The regulations were so stringent that as many as 40 Oklahoma hospitals could have closed because of their inability to meet the review requirements. OSMA, OHA, and OOA, working with the Oklahoma Congressional delegation and federal officials, developed an alternative review system utilizing regional review teams of physicians and retrospective computerized hospital audits. OURS (Oklahoma Utilization Review System) was implemented in late 1976 and served as the federal government's official Medicare and Medicaid review system in Oklahoma until the PSRO program was implemented in 1979. The success of the OURS project was obvious to physicians and hospital officials, but two major evaluations conducted by the government could not clearly establish a cause-and-effect relationship, nor could they produce irrefutable statistical evidence that practice patterns of physicians and hospitals had changed as a result of the program.

However, similar evaluations of PSROs across the nation were producing similar results. Because the Oklahoma plan was less expensive and interfered less with patient care, DHEW approved the OURS project as a conditional PSRO in May of 1978. Some changes resulted in the transition from OURS to PSRO, but the basic tenets of retrospective review and regional peer review were preserved.

The Foundation operated the PSRO program until September 30, 1983. Legislation changing PSROs to PROs (Professional Review Organizations) was passed by the Congress and was scheduled for implementation beginning October 1, 1983.

While PRO is still a review of Medicare and Medicaid hospitalization, the nature of the review has changed dramatically. OURS and PSRO were basically retrospective review programs and only prospective if sufficient evidence indicated chronic abuse by a physician or hospital, and then only if a physician peer review group decided it was appropriate. PSRO is basically a prospective review and concurrent review system, establishing by contract certain procedures and illnesses that must be pre-certified prior to admission, and setting numerical quotas of cases that must be reviewed. The primary purpose of the PRO program is to either keep people out of the hospital or to encourage that certain procedures or treatments be performed on an outpatient basis.



At the inaugural ball, Pam Oster, OSMA Auxiliary president for 1984-85, displays the certificate of appreciation she received. Looking on are James B. Eskridge III, MD, (standing) OSMA president 1984-85, and Lanny F. Trotter, MD, Stillwater, general chairman of the 1985 OSMA Annual Meeting Planning Committee.

PROs are established by contract with the Health Care Financing Administration. Contracts were bid by physician organizations who could demonstrate by proposal that they could perform review as outlined in HCFA's Request for Proposal. All organizations bid on the same specifications. Variances in methodology arise out of demographics, unique characteristics, size of hospitals, geography, and the ability to negotiate.

Because of the major philosophical differences between the PRO and PSRO, a special meeting of the House of Delegates was called to determine if OSMA should endorse OFPR's application to become the PRO for Oklahoma. The House in session on November 19, 1983 voted to support the OFPR bid for the PRO contract.

### PRO Implementation

On two occasions the OFPR bid was rejected by HCFA as technically unacceptable; however, after lengthy and arduous negotiations, a third attempt was approved by HCFA and reluctantly ratified by the OFPR Executive Committee. The program was to be implemented effective November 1, 1984. Because Oklahoma physicians and hospitals were ill-formed and unprepared to implement the new program, OSMA, OHA, and OOA requested a delay in implementation until *December 1, 1984*, of most of the requirements in the PRO contract. The extension was granted.

Since the implementation date, OFPR has reviewed under each objective the following:



*Admission Objective #1* — Reduce admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting or on an outpatient basis.

<u># Reviews</u>	<u># Denials</u>
336	7
4th Quarter '83 Admissions	4th Quarter '84 Admissions
3,332	1,942
Reduction = 1,390	

*Admission Objective #2* — Reduce the number of inappropriate or unnecessary admissions or invasive procedures for specific diagnosis-related groups.

<u># Reviews</u>	<u># Denials</u>
794	15
4th Quarter '83 Admissions	4th Quarter '84 Admissions
10,235	4,971
Reduction = 5,264	

*Admission Objective #3* — Reduce the number of inappropriate or unnecessary admissions or invasive procedures in specific hospitals.

<u># Reviews</u>	<u># Denials</u>
2	1
4th Quarter '83 Admissions	4th Quarter '84 Admissions
631	360

# Physicians on 100% Review — 11 for 4th Quarter '84

*Quality Objective #1* — Reduce unnecessary hospital readmissions resulting from substandard care provided during the prior admission.

# Reviews: 88	
Results: 1 Denied	
4th Quarter '83 Admissions	4th Quarter '84 Admissions
2,936	729
Reduction = 2,207	

*Quality Objective #2* — Assure the Provision of Medical Services which, when not performed, have "significant potential" for causing "serious patient complications."

# Reviews: 2,244	
Results: 245 had problem	
4th Quarter '83 Admissions	4th Quarter '84 Admissions
5,696	1,225
Reduction = 4,471	

*Quality Objective #3* — Reduce by 2.5 (90 cases) avoidable deaths for certain DRGs involving Cardiovascular Disorders.

# Reviews: 79	
Results: 0 Denied	
4th Quarter '83 Admissions	4th Quarter '84 Admissions
456	348
Reduction = 108	

*Quality Objective #4* — Reduce unnecessary surgery or other invasive procedures.

# Reviews: 5	
Results: 0 Denied	
4th Quarter '83 Admissions	4th Quarter '84 Admissions
2,911	2,283
Reduction = 628	

*Quality Objective #5* — Reduce postoperative or other complications.

# Reviews: 2,244	Total Admissions
Results: 207 had problem	Reductions for the period = 14,428

The PRO program has not been implemented without controversy. While OFPR made heroic efforts to inform physicians and hospitals about the new review procedures, they neither had the time nor the personnel to accomplish a smooth transition from PSRO to PRO. The process was further confused by conflicting and confusing mandates from HCFA.

### Current Situation

At the present time the PRO program is functioning, comparatively speaking, smoothly. All hospitals have experienced at least one foundation review and some have had more. Pre-admission review procedures have been shortened and streamlined. Appellate review is being done on a timely basis by practicing physicians not directly connected with OFPR. The OSMA, OOA, OHA, and OFPR have met frequently to resolve special problems. New procedures have been implemented to assure expeditious and equitable treatment to physicians and hospitals that have special problems.



Orange M. Welborn, MD, Ada, a past president of OSMA, and Rollie E. Rhodes, Jr., MD, president of the Tulsa County Medical Society, discuss upcoming business in the House of Delegates.

Summary and Recommendations

The PRO program was enacted by the Congress, and the care received by each Medicare and Medicaid patient is subject to review as specified by the law and regulations promulgated by HCFA. OFPR currently holds the contract for conducting the review in Oklahoma, and while OFPR was organized and initially funded by OSMA, OOA, and OHA, it is a separate and autonomous corporation authorized to do business under Oklahoma law.

OSMA, OOA, and OHA have a strong influence on OFPR as evidenced by the OURS and PSRO programs and the delay granted for implementation of the PRO program.

If changes can be affected in the PRO program, they can probably be best accomplished by a consortium of OFPRs sponsoring organizations.

After reviewing all the information made available to your Ad Hoc Committee, we recommend that the association continue to endorse OFPR as the preferred contractor for implementation of the PRO program, subject to the adoption by the OSMA Board of Trustees and the House of Delegates, and the OFPR Board of Directors, the following principles to guide the relationship between the two organizations that:

1. Communications between OFPR and Oklahoma physicians should be improved and strengthened. Letters to doctors should be reviewed and approved by a physician to ensure that the message is clear and concise. Conversely, the leadership of OSMA should communicate directly with the physicians on the OFPR Board to make certain that the feelings of the OSMA membership are clearly expressed at OFPR Board meetings;
2. Changes in OFPR's review procedures that affect patients and physicians are presented directly to physicians in advance of implementations and that a lead time of 6 months be required before substantive changes are made. Should HCFA or other governmental agencies insist upon requirements that violate professional conduct or quality patient care, OSMA should pledge to OFPR its strong support for political opposition to such violations;
3. OSMA and OFPR periodically submit articles to the OSMA JOURNAL and other publications detailing the accomplishments of the review program and how OFPR's programs enhance patient care and cost containment;
4. The OFPR Board place a moratorium on the consideration of private peer review contracts until such time that it can demonstrate conclusively that OFPR's review program is in the best interest of patient care in Oklahoma.

Respectfully submitted,  
John A. McIntyre, MD, Chairman  
Elvin M. Amen, MD  
George M. Brown, Jr., MD  
Elaine N. Davis, MD  
Norman L. Dunitz, MD  
Burdge F. Green, MD  
James V. Miller, MD  
Lee N. Newcomer, MD  
Kenneth W. Whittington, MD

Report of the  
JOURNAL OF THE  
OKLAHOMA STATE MEDICAL ASSOCIATION

An Addendum to the Report of the Council on Professional and Public Relations

Subject: **Annual Report**  
Presented by: Mark R. Johnson, MD, Editor-in-Chief  
Referred to: Reference Committee II

The JOURNAL of the Oklahoma State Medical Association has maintained its position as one of the nation's finest medical publications by providing its readers with timely, significant scientific articles and special feature stories. The JOURNAL remains a very popular and important benefit of membership in the association.

The style, content, and graphics of the JOURNAL continue to compare favorably with other medical publications while augmenting the JOURNAL's quiet, sophisticated appearance. Subtle changes continue to be made in the effort to make the publication even more readable.

The "Leaders in Medicine" series will continue to be a feature in selected issues. The articles will focus on Oklahoma physicians who have made significant contributions to medicine in the state and, in the opinion of the Editorial Board, deserve to be recognized for their accomplishments. Featured in 1984 were Malcom E. Phelps, MD (March) and Edward K. Norfleet, MD (September).

The Editorial Board, at its annual meeting in February, selected the winners of the \$500 Charlotte S. Leebron Memorial Trust Award, given annually to the authors of the best scientific paper published in the JOURNAL. The 1984 award will be shared by Mark H. Mellow, MD, and Gretchen A. McCoy, MD, for their paper "Endoscopic Laser Therapy in the Palliative Treatment of Colorectal Carcinoma: A Case Report," appearing in the November issue. The award is presented at the OSMA's Annual Meeting each May.

In further action, the Editorial Board voted not to increase member and domestic subscription rates in deference to the existing physician fee freeze and other cost containment efforts. Effective January 1, 1986, however, the foreign subscription rate will be increased to \$28 in order to cover the cost of production and mailing.

The board decided there should be no increase in advertising rates for 1986.

Respectfully submitted,  
Mark R. Johnson, MD  
Editor-in-Chief

Harris D. Riley, MD  
Editor

Robert G. Tompkins, MD  
Editor



## RESOLUTION 1

(Adopted as Amended)

Introduced by: Tulsa County Medical Society  
Subject: **Ending Tobacco Subsidies**  
Referred to: Reference Committee II

WHEREAS, Exposure to cigarette smoke has been shown to cause increased episodes of asthma in allergic individuals, increase in pulmonary infections in infants and young children, increase in premature and low birth weight for gestational age, increase in chronic obstructive pulmonary disease, lung cancer and bladder cancer; and

WHEREAS, The Surgeon General has caused a warning to be placed in cigarette packages stating in part that "Cigarette smoking is dangerous to your health"; and

WHEREAS, There is mounting evidence that smokeless tobacco is associated with pre-cancer and cancerous oral disease; and

WHEREAS, These diseases cause chronic disability and increase the cost of health care, particularly Medicare; and

WHEREAS, All Americans directly contribute to these problems through the use of their tax dollars to subsidize the tobacco-growing industry; and

WHEREAS, It is rationally inconsistent for the Surgeon General to condemn tobacco smoking and for the United States Congress to support tobacco growers through subsidies; and

WHEREAS, In an attempt to reduce the federal deficit, the President has presented a budget to Congress that plans to reduce both Medicare expenditures and other farm subsidies; now therefore be it

*Resolved*, That the Oklahoma State Medical Association go on record as opposing federal subsidies to the tobacco industry and urge Congress to end such subsidies; and be it further

*Resolved*, That the Oklahoma State Medical Association introduce a similar resolution to the House of Delegates of the American Medical Association for consideration at its annual meeting in June, 1985.



Margaret Eskridge, OSMAs outgoing first lady, receives a special gift from newly installed OSMAs President Elvin M. Amen, MD, during the president's inaugural dinner.

## RESOLUTION 3

(Not Adopted)

Introduced by: Tulsa County Medical Society  
Subject: **Prohibition of Smoking in all Patient Areas of Hospitals**  
Referred to: Reference Committee II

WHEREAS, It is not the public policy of the State of Oklahoma to deny anyone the right to smoke, but when this occurs in health care facilities, both patients and non-patients are affected by this act; and

WHEREAS, The right of the non-smoker, especially a patient, to breathe clean air should supersede the right of a person to smoke; and

WHEREAS, The public is very concerned now about health care costs, and if the Oklahoma State Medical Association will take a firm stand against the most common cause of premature death in the United States, this will improve the image of the physician; and

WHEREAS, Thirty percent of all cancer deaths are caused by smoking and twenty-five per cent of all Medicare and Medicaid costs are the results of smoking, hospitals and medical societies should not indirectly condone this form of self-destructive habit; and

WHEREAS, Smoking constitutes a fire hazard which is a very serious consideration in the hospital setting, especially when it is known that many fires in residences are caused by people smoking in bed; and

WHEREAS, Tobacco smoke provides patients in Intensive Care Units and Coronary Care Units with less than an ideal environment for recovery; and

WHEREAS, Breathing of secondary smoke may prolong the length of stay of certain hospital patients; and

WHEREAS, Hospitals in other states have successfully banned smoking in all patient areas, and in some cases no longer employ persons who smoke; now therefore be it

*Resolved*, That the Oklahoma State Medical Association urge all Oklahoma hospitals, including the members of the Oklahoma Hospital Association and state and federally operated hospitals, to ban smoking in all patient care areas in hospitals; and be it further

*Resolved*, That the Oklahoma State Medical Association encourage the Oklahoma State Legislature to enact legislation banning smoking in all patient care areas in Oklahoma hospitals.

## RESOLUTION 5

(Adopted)

Introduced by: OSMAs Council on Public & Mental Health  
Subject: **Mental Health Programs**  
Referred to: Reference Committee II

WHEREAS, Direct patient care enhances the quality of medical education; and

WHEREAS, Medical trainees should have clinical experience in settings where they may practice; and



Enjoying themselves during the Annual Meeting festivities are Floyd F. Miller, MD, (left) Tulsa, a past president of OSMA and current delegate to the AMA, and Robert G. Perryman, MD, Tulsa, vice-speaker of the OSMA House of Delegates.

WHEREAS, The Oklahoma State Medical Association continues to support medical-psychiatric leadership in the public mental health programs of the state; and

WHEREAS, There is a shortage of psychiatrists in public mental health programs; now therefore be it

*Resolved*, That the Oklahoma State Medical Association strongly encourages the University of Oklahoma Department of Psychiatry and Behavioral Sciences in Oklahoma City to enhance its training program to respond to the need for additional psychiatrists in Oklahoma public mental health programs; and be it further

*Resolved*, That the Oklahoma State Medical Association further encourages a closer affiliation between the University Training program and that of the Oklahoma Department of Mental Health. Sharing of resources between these two organizations can only be of benefit to the state of Oklahoma, resulting in improved quality of care of the mentally ill and a more efficient allocation of scarce resources.

## RESOLUTION 7

(Adopted)

Introduced by: Council on Medical Services

Subject: **Truth in Advertising**

Referred to: Reference Committee II

WHEREAS, Federal Trade Commission rulings in regard to advertising by physicians or groups of physicians have resulted in a substantial increase in direct advertising, both printed and broadcast; and

WHEREAS, There has been a tendency by some physicians to utilize these methods of publicity to promote certain unproven remedies in treatment of various conditions; and

WHEREAS, The general public simply does not have the background knowledge and information or insight into the

pros and cons of scientific research on these subjects to make critical decisions and elect options on their health care that may, and frequently do, affect their health and long-term prognosis; and

WHEREAS, Occasional sincere and honorable attempts to enlist the aid of the public in specific medical research projects occasionally result in false and misleading information to the general public because media sources, particularly the broadcast media, are more interested in the sensationalism of the project than a desire to convey accurate scientific information; and

WHEREAS, There is an increasing demand by many physicians throughout the state of Oklahoma that the OSMA accepts responsibility to present to the general public scientific and accurate information on medical progress in these areas of advertising unproven remedies; and

WHEREAS, In the past we have simply ignored these types of false and deceptive advertising by physicians or groups of physicians; now therefore be it

*Resolved*, That the Oklahoma State Medical Association engage in the next three years in a formal public information program with the express purpose of calling attention to the pros and cons of those areas of medicine that are currently receiving a great deal of formal advertising of unproven remedies and which in fact are officially disapproved by the American Medical Association; and be it further

*Resolved*, That when there is an error in presenting this information to the public, by physicians or institutions, that the said physicians or institutions should be encouraged by the OSMA to present to the public a balanced and scientific view on medical progress in those areas.

## RESOLUTION 10

(Adopted as Amended)

Introduced by: Council on Medical Services

Subject: **Radial Keratotomy**

Referred to: Reference Committee II

WHEREAS, Random controlled trials and other established methods of scientific inquiry are essential in evaluating the safety and efficacy of medical practices, products, and drugs; and

WHEREAS, Physicians, both in the private sector and institutions throughout the country, are essential to the conduct of such inquiry and evaluation; and

WHEREAS, Recent litigation has threatened the ability of these physicians and institutions to participate in such studies; now therefore be it

*Resolved*, That the AMA scientific and legal staff and councils seek the collaboration of the National Institutes of Health and other leaders in the legal and scientific communities to ~~access~~ **assess** the implications of PERK (Prospective Evaluation of Radial Keratotomy) and report to the House of Delegates at the Interim-85 Meeting with recommendations for a course of action for the AMA and the Federation to follow.



Late Resolution  
**RESOLUTION 16**

(Adopted)

Introduced by: Council on Medical Services  
Subject: **Reactivation of Fee Review Committee**  
Referred to: Reference Committee II

WHEREAS, the Oklahoma State Medical Association has always been on record as supporting peer review of fees and only ceased the function because of possible anti-trust liability; and

WHEREAS, peer review of fees represents a valuable

service to the public by the OSMA; and

WHEREAS, the Federal Trade Commission has now publicly endorsed the concept of professional peer review of fees if the particular program in question does not violate the anti-trust laws in its design or its operation; now therefore, be it

*Resolved*, that the Oklahoma State Medical Association reactivate its peer review mechanism and protocol of the past, which would report to the Council on Medical Services; and be it further

*Resolved*, that the activities of the Fee Review Committee be separate and distinct from those activities of the Appropriateness Review Committee which now functions.



Taking a break from their hectic Annual Meeting schedules, OSMA staff members enjoy an evening as guests at the OSMA Board of Trustees dinner. From left to right around the table are Ann McWatters, secretary to associate directors Otie Ann Carr and Robert Baker; Susan Meeks, secretary to associate director Mike Sulzycki and deputy executive director Rick Ernest; Susan Harrison, managing editor of the OSMA JOURNAL; Toni Leverett, secretary to executive director David Bickham; Kathy Burnett, membership secretary; Debbie Hinson, secretary to OSMA legal counsel Ed Kelsay; Beth Dumler, receptionist and switchboard operator; and Shirley Burnett, administrative assistant.

# REPORTS to the OSMA House of Delegates Referred to Reference Committee III

## Report of the COUNCIL ON GOVERNMENTAL ACTIVITIES

Subject: **Annual Meeting**

Presented by: Perry A. Lambird, MD, Chairman

Referred to: Reference Committee III

### Introduction

Escalating medical care costs and rising federal deficits have caused intense scrutiny of America's medical delivery system. Every proposal and law reflects congressional concern over rising costs. The Council, as in years past, is devoting vast amounts of time and effort to deal with and influence congressional action. Through the help of Mr. John Montgomery, our Washington liaison, the AMA Washington office and OSMA officer efforts, the Council feels that we have been successful. This report will review the highlights of our federal legislative activities.

### Activities

OSMA's federal government relations program is a "first" within the federation and has proven to be an effective and cost efficient strategy for influencing health policy in Washington, DC. The Oklahoma congressional delegation has been receptive to the Association's visits to Washington and the Association has, in turn, been responsive to congressional requests for information and advice.

In a recent Council meeting with Mr David Cox, chief assistant on health matters to Senator David Boren, the Council agreed that opposition to legislation dealing with the health/cost dilemma is not enough. The Council agreed that we must dedicate ourselves to defining and developing alternative proposals to assist Congress.

One alternative, diligently drafted, redrafted and eventually finalized is the *Medicare Demonstration Project*. This proposed legislation, modeled after our PLICO Health, would rearrange Medicare's deductible and coinsurance features to a front-end, one time (per year) payment and would also provide for a payment of a "Stay-Well Bonus" if the beneficiary did not use the policy during a one year period. Each participant would have a trust fund from which he would pay for his medical expenditures. Objectives of the legislation will include: reducing overall Medicare expenditures because of more patient cost awareness; elimination of many small claims; and a reduction in utilization because of a higher front-end deductible. The *Medicare Demonstration Project* will be introduced in the 99th United States Congress, 1985 and the OSMA has requested full coauthorship from our congressional delegation. Although this project has taken three years to complete, the legislation supported by the Oklahoma Hospital Association is a definitive alternative proposal to the health/cost dilemma.

On February 4, 1985, President Reagan presented his budget for fiscal year 1986 to Congress. The first concrete actions taken with respect to the budget were in the Senate Budget Committee which on March 14 reported out its first budget resolution including directives to each of the other senate committees on deficit reduction actions to be taken. As expected, the Senate Budget Committee cut most domestic spending programs less severely than Reagan had requested. With respect to Medicare, the Committee incorporated the President's freeze on physicians' fees for one more year, along with a one year freeze on hospital DRG payments. However, these actions are by no means final and the budget must now go before the full Senate and a comparable resolution will be released in the House. All reconciliation action by committees must be completed by June 15th. The Council on Governmental Activities is studying the budget at the present time.

### Mandatory Medicare Assignment

The most controversial issue to come before Congress last year would require that all physicians with hospital staff privileges agree by contract to accept assignment on all Medicare patients. The assignment issue had strong support from a democratic leadership in the House of Representatives and from senior citizens' groups nationwide. During the second session of the 98th Congress (1984), the issue of budget savings was the driving force behind congressional activity that resulted in substantial modifications to the Medicare and Medicaid programs. The House and Senate committees initially began consideration of modifications to the Medicare and Medicaid programs in the first session of the 98th Congress and additional considerations of the Senate Finance Committee were completed in late February, 1984. The House of Representatives did consider a proposal to freeze physicians' fees coupled with mandatory assignment in its floor deliberations on budget reconciliation. That proposal, however, was defeated on a voice vote. The Council on Governmental Activities, the OSMA, and the AMA adamantly opposed this bill. Although the mandatory assignment issue is presently dead the Council, as well as the OSMA and AMA, are preparing for the possibility of the bill being reintroduced in this year's Congress.

### Physician DRGs

The future of Medicare Part B payments is receiving some discussion on Capitol Hill. Ms Carol Kelly, a spokeswoman for HCFA, believes that physician DRGs are still very much under consideration. However, Dr William Roper, special health assistant to President Reagan, has expressed serious reservations about the viability of a DRG model for physician payments. Key staff from Senator David Durenberger's office and Dr Roper are presently expressing more interest in long-term reform based on capi-



tation or vouchers rather than the physician DRG approach. HCFA's report to the Congress on Part B is due July 1, however, even if the report is on time, there appears little chance that Congress will have sufficient time to overhaul Part B in 1985.

#### **Senate Finance Committee's Subcommittee on Health**

The key senate committee with jurisdiction over Medicare and Medicaid was expanded this year. Senator David Darenberger (R-MN) will remain as chairman and Oklahoma's David L. Boren has also obtained a seat on this important committee.

#### **OSMA Delegation Meetings with Congress**

An OSMA delegation met with Oklahoma's congressional delegation and staff in mid-April, 1985 in Washington, DC. The delegation, headed by OSMA President James B. Eskridge, III, MD, stressed strong opposition to the continued freeze. Our delegation stressed that physicians have been taking responsible actions through our voluntary freeze in 1984/1985 and that 80% of United States physicians took part voluntarily. The delegation was quick to point out that this voluntary freeze resulted in nearly 1.5 billion dollars in savings.

Other points argued in Washington, DC were:

- (1) Physicians are being singled out inappropriately (No other group receiving federal government payment had their payment level frozen).
- (2) Physician reimbursement levels under Medicare will further lose touch with actual customary charges for services. (If the freeze is extended, physicians will not be allowed any increase on October 1, 1985. The result of these delays is that Medicare will be paying for services from the period of October 1, 1986 to September 30, 1987 based on charges last updated on July 1, 1983 from data compiled in 1982.)
- (3) A mandatory freeze will discourage Medicare participation. (The initial Medicare freeze has caused some physicians to limit and even curtail their treatment of Medicare beneficiaries.) Congress must remember that physicians' overhead costs are rising, including costs for liability insurance. Medicare reimbursement levels have made no allowances to recognize the rising costs placed on physicians.

Basically, the Council on Governmental Activities, the OSMA, AMA, AARP, AFL-CIO, AHA, ANA, and numerous other organizations stand together urging Congress to reject proposed further reductions. The basic argument is that these reductions "will harm those who can least afford it, and it will threaten to erode the quality of health delivery, as well as jeopardize access to the health systems, resulting in a larger financial burden for workers and their families."

Presently, the Council is reviewing and developing alternative proposals to assist Congress with health legislation. Below is a list of the Council on Governmental Activities' preliminary motions. The Council on Governmental Activities:

- A. Opposes mandatory assignment and supports the direction taken by the American Medical Association and intends to follow their lead in opposing mandatory assignment.
- B. Supports means testing as a viable option for further discussion.
- C. Will continue its opposition to last year's Kennedy/Gephardt legislation, if reintroduced.
- D. Supports future discussions and review of medical IRAs as a possible alternative.
- E. Supports future review of indemnity as an alternative proposal.
- F. Supports continued study of the relative value scale for physician's services.
- G. Opposes DRGs for physician services.
- H. Opposes competitive bidding for laboratory services.

#### **Conclusion and Recommendations**

The OSMA will continue sending delegations to Washington, DC, to meet with our congressional delegation. Presently, few bills have been introduced however, the Council will continue to monitor congressional action daily and we will report in great detail as legislation is introduced.

The Council is requesting an increase in its budget to remain as an active lobbying force in Congress. The requested budget increase is no larger than this Council's budget for 1981.

#### **Budget Request \$15,500\***

\*Does not include salary of John Montgomery

Respectfully submitted,  
 Perry A. Lambird, MD, Chairman  
 Richard J. Boatsman, MD  
 William D. Borkin, MD  
 Stephen K. Cagle, MD  
 Ed L. Calhoon, MD  
 Charles D. Cook, MD  
 Jerome M. Dilling, Jr., MD  
 Curtis E. Harris, MD  
 Mark A. Hayes, MD  
 George H. Kamp, MD  
 George M. Pikler, MD  
 Garland N. Porterfield, Jr., MD  
 Christian N. Porterfield, Jr., MD  
 C. B. Rebsamen, Jr., MD  
 Ronald H. White, MD  
 James A. Young, MD  
 William L. Hughes, MD  
 Mrs. Ellie Idstrom  
 Mrs. Veronica Montero  
 Mr. John Montgomery  
 Mrs. Pam Oster  
 Mr. Ross VanHooser  
 Mr. Joe Andrezik

## Report of the COUNCIL ON STATE LEGISLATION

Subject: **Annual Report**

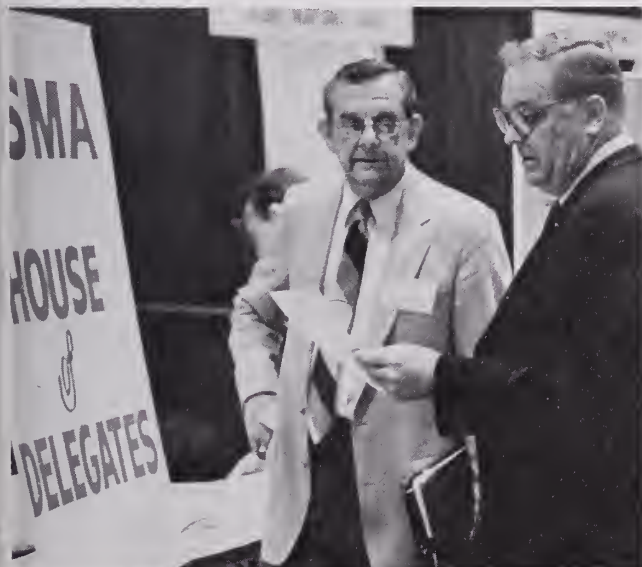
Presented by: William L. Hughes, MD, Chairman

Referred to: Reference Committee III

At the writing of this report, the 40th Session of the 1985 Legislature is half way through its session. It is hard to believe that May 9 is the deadline for senate bills to be reported out of house committees and the deadline for house bills to be reported out of senate committees. That means, for all practical purposes, we have completed business on a bill in one house only. Please keep that in mind as you review the status of the bills on the following pages.

As you can tell by the asterisk, there are still a number of bills to be worked on before the close of session. Several bills will be going to conference committee. We will be working with the leadership on favorable conferees so that we can have maximum input regarding these bills.

All in all it has been a good year to date. To those members involved in CONTACT, a special thanks. The personal relationships that are being established with physicians and their own legislator(s) are invaluable. We have seen the difference it has made on several of the bills this year. As physician members of the Oklahoma State Medical Association, you are to be commended for your time in responding to legislative alerts by contacting your legislators. The State Legislative Council has given a great deal of time and assistance to this effort during bi-weekly meetings. In addition, we have been encouraged by the Senate and House leaderships' involvement in medical issues. Almost, without exception, we have been given the support of the leadership on legislative issues that have been important to us.



Don Blair (left), former OSMA executive director and now vice-president at C.L. Frates & Company, confers with OSMA Executive Director David Bickham in the exhibit hall before returning to the House session.

We must not stop with just legislative contact; however, we must also become involved in OMPAC (if you aren't a member) and local legislative campaigns. To be successful at the legislature, it takes three things: (1) a personal relationship with your legislator(s); (2) a strong PAC; and (3) some local political involvement. It just won't work unless all three components are working. We need your commitment to these three areas this year. This is a group effort but it takes *individuals* to make up the group. While pondering the extent of your involvement, keep these ten two-letter words in mind . . . "If it is to be, it is up to me."

### Budget Request \$51,000.00

Respectfully submitted,  
William L. Hughes, MD, Chairman  
Nolen L. Armstrong, MD  
M. Tom Buxton, Jr., MD  
Raymond L. Cornelison, Jr., MD  
Billy D. Dotter, MD  
Robert S. Ellis, MD  
Steven D. Jimerson, MD  
William P. Jolly, MD  
John F. Josephson, MD  
William J. Kruse, MD  
Lee N. Newcomer, MD  
Gary L. Paddock, MD  
Michael J. Schwartz, MD  
Charles R. Vest, MD  
Edgar W. Young, Jr., MD  
Mark R. Johnson, MD  
Perry A. Lambird, MD  
Joan K. Leavitt, MD  
Larry L. Long, MD  
Charles B. McCall, MD  
Walter H. Whitcomb, MD  
Stephen E. Acker, MD  
Jerry Vannatta, MD  
Mr. George F. Short, Attorney  
Mrs. Ellie Idstrom  
Mrs. Veronica Montero  
Mr. Mark Gregory  
Ms. Suzanne Miller

### STATUS OF SENATE BILLS April 15, 1985

The following is a list of the legislation being monitored by the Oklahoma State Medical Association:

- \*SB 63     **Oklahoma Mandatory Seat Belt Use Act.** Requiring operators and front seat passengers to wear seat belts. OSMA POSITION: actively support. STATUS: House Public Safety Committee.
- SB 87     **Creating the Oklahoma State Licensing Board** to perform all administrative functions of 31 licensing boards. OSMA POSITION: Actively oppose. STATUS: Dormant.
- SB 122    **Allowing plaintiffs to dismiss civil actions** without prejudice 10 days before the trial date. OSMA POSITION: Support. STATUS: Dormant.
- SB 123    **Limiting percentage of liability** when two or more defendants are involved in negligence or product liability case. OSMA POSITION: Support. STATUS: Dormant.
- SB 127    **Providing that information concerning conditions and treatment of patients** is subject to discovery by parties to a medical malpractice suit. OSMA POSITION: Strongly Oppose. STATUS: Dormant.



- \*SB 135 **Prohibiting school volunteers from eliciting certain information by oral survey or examination of students.** OSMA POSITION: Monitor. STATUS: House Education Committee.
- \*SB 151 **Oklahoma Boards and Commissions Uniform Districting Act.** OSMA POSITION: Monitor. STATUS: House Rules Committee.
- \*SB 176 **Adding psychologists to the definition of physician in the Workers' Compensation Act.** OSMA POSITION: Oppose. STATUS: House Industry & Labor Relations Committee.
- SB 194 **Providing for joint and several liability for a single harm.** OSMA POSITION: Oppose. STATUS: Dead.
- SB 200 **Prohibits a physician from performing an abortion on a minor without first notifying a parent or guardian.** OSMA POSITION: Monitor. STATUS: Dormant.
- \*SB 219 **"Alcoholism and Drug Dependency Treatment Insurance Act." To include benefits for the treatment of the illness of alcoholism and drug dependency in all health insurance contracts issued in this state.** OSMA POSITION: Monitor. STATUS: House Mental Health Committee.
- \*SB 229 **Oklahoma Comprehensive Mental Health Services for the Deaf and Hearing Impaired Act.** OSMA POSITION: Monitor. STATUS: House Mental Health Committee.
- SB 240 **Providing for products liability lawsuits; providing a defense of contributory negligence.** OSMA POSITION: Support. STATUS: Dormant.
- SB 242 **Providing that equal contributory negligence shall prevent recovery for certain damages; limiting liability of any party to their percentage of negligence.** OSMA POSITION: Support. STATUS: Dormant.
- \*SB 261 **Restructuring the size and composition of various boards and commissions in accordance with the Oklahoma Boards and Commissions Uniform Districting Act.** OSMA POSITION: Support. STATUS: House Rules Committee.
- \*SB 265 **Setting interest rates on certain judgments by courts of record.** OSMA POSITION: Actively Support. STATUS: House Industry and Labor Committee.
- SB 274 **Authorizing establishment of preferred provider insurance policies; requiring insurers to establish conditions to be met by health care providers in order to qualify as preferred provider.** OSMA POSITION: Monitor. STATUS: Dormant.
- \*SB 284 **Authorizes the Board of Chiropractic Examiners to examine applicants in additional subjects; modifying grounds for suspending or revoking licenses; creating Oklahoma Chiropractic Code of Ethics.** OSMA POSITION: Oppose. STATUS: Passed House. Returned to Senate.
- \*SB 303 **Permitting superintendents of mental hospitals to be graduates of schools of osteopathic medicine.** OSMA POSITION: Support. STATUS: House Mental Health Comm.
- \*SB 305 **Defining usual, customary and reasonable fees; prohibiting healing arts practitioners from certain types of advertising.** OSMA POSITION: Monitor. STATUS: Amended but failed to pass House.
- \*SB 309 **Eliminating requirement for medical examiner death certificates in certain cases.** OSMA POSITION: Support. STATUS: House Public Health Committee.
- SB 310 **Modifying interest rates on judgments by courts of record.** OSMA POSITION: Support. STATUS: Dormant.
- SB 311 **Defining usual, customary, and reasonable fees charged by healing arts practitioners.** OSMA POSITION: Oppose. STATUS: Dormant.
- SB 342 **Allowing establishment of preferred provider insurance policies; requiring insurer to establish conditions to be met by health care providers.** OSMA POSITION: Oppose. STATUS: Dormant.
- SJR 3 **Proposed constitutional amendment authorizing the legislature to set statutory limits on damages for injuries resulting in death.** OSMA POSITION: Monitor. STATUS: Filed with Secretary of State.
- SJR 20 **Directing the Department of Human Services to expand Medicaid coverage; directing the Commission for Human Services to add certain types of medical coverage.** OSMA POSITION: Support. STATUS: Dormant.



Joseph W. Stafford, MD, Enid, of the OSMA Board of Trustees, stops at the registration desk en route to his first meeting.

**STATUS OF HOUSE BILLS**  
April 15, 1985

The following is a list of the legislation being monitored by the Oklahoma State Medical Association:

- \*HB 1070 Recreating State Board of Electrology.** OSMA POSITION: Monitor. STATUS: House rejects Senate amendments. In conference.
- \*HB 1071 Recreating State Board of Examiners of Psychologists.** OSMA POSITION: Monitor. STATUS: To Governor.
- HB 1100 Providing for joint and several liability of joint tortfeasors for single harm.** OSMA POSITION: Oppose. STATUS: House Judiciary Committee. Dormant.
- HB 1129 Redefining physical therapy and other terms; outlining duties of Physical Therapy Committee and requiring members to be licensed.** OSMA POSITION: Support. STATUS: House Professions & Occupations. Dormant.
- \*HB 1163 "Licensed Professional Counselors Act."** OSMA POSITION: Oppose. STATUS: Senate General Order.
- \*HB 1164 Removing required per diem payments and authorization for reimbursements of certain expenses of numerous state entities.** OSMA POSITION: Oppose. STATUS: Senate Appropriations Committee.
- \*HB 1165 "Oklahoma Natural Death Act."** OSMA POSITION: Monitor. STATUS: Senate Human Resources Committee.
- HB 1168 "The Political Committee Regulation Act."** OSMA POSITION: Monitor. STATUS: House Rules. Dormant.
- HB 1172 Providing that contributory negligence shall not prohibit recovery for certain damages; limiting liability to the percentage of negligence.** OSMA POSITION: Support. STATUS: Dormant.
- \*HB 1189 Authorizing donation of pituitary glands after removal during autopsies.** OSMA POSITION: Support. STATUS: Senate Human Resources Committee.
- \*HB 1195 Allowing for defense of contributory negligence in product liability court actions.** OSMA POSITION: Support. STATUS: Senate Judiciary & Retirement Committee.
- \*HB 1203 Requiring doctor or hospital to apply to court to prevent partial or complete release of psychiatric records; limiting copying fee to maximum of 25 cents per page.** OSMA POSITION: Actively Support. STATUS: Senate Judiciary & Retirement Committee.
- \*HB 1222 Creating an Oklahoma indigent health care fund and allowing income tax checkoff.** OSMA POSITION: Monitor. STATUS: Senate Finance Committee.
- \*HB 1223 Prohibiting certain health care professionals and others from charging for diagnostic tests unless they supply patient with certain information.** OSMA POSITION: Work On. STATUS: Senate Business & Labor.
- \*HB 1230 "Uniform Determination of Death Act."** OSMA POSITION: Monitor. STATUS: Senate Judiciary & Retirement Committee.
- HB 1231 Providing for placement or destruction of certain animals and prohibiting making random-source animals available for research, testing, or experimentation.** OSMA POSITION: Oppose. STATUS: House Public Health. Dormant.
- \*HB 1247 Oklahoma Comprehensive Mental Health Services for the Deaf and Hearing Impaired Act.** OSMA POSITION: Oppose. STATUS: Senate Human Resources Committee.
- HB 1249 Prohibiting pharmacists from selling syringes to minors unless said minor provides the pharmacist with his name and address and name of his physician.** OSMA POSITION: Monitor. STATUS: House Public Health. Dormant.
- HB 1272 "Oklahoma Organ Transplant Financial Assistance Act."** OSMA POSITION: Monitor. STATUS: House Public Health. Dormant.
- \*HB 1281 Modifying the term "Imitation Controlled Substance" to include those so similar as to give a like effect.** OSMA POSITION: Support. STATUS: Senate Human Resources Committee.
- \*HB 1297 Authorizing municipalities to regulate privately operated licensed emergency medical service providers.** OSMA POSITION: Monitor. STATUS: House General Order.
- HB 1304 Levying a \$10 annual surcharge on life, accident and health insurance policies issued in the state; creating the "Catastrophic Indigent Care Fund" for the Department of Human Services.** OSMA POSITION: Monitor. STATUS: House Revenue & Taxation. Dormant.
- \*HB 1311 Providing for the admittance of informal patients to certain facilities.** OSMA POSITION: Support. STATUS: Senate General Order.

- \*HB 1318 Oklahoma Occupational Hearing Loss Act.** OSMA POSITION: Oppose. STATUS: Senate Judiciary & Retirement Committee.
- HB 1320 Allowing injured employee to select a physician mutually agreed to between employer and employee.** OSMA POSITION: Support. STATUS: House Insurance. Dormant.
- HB 1325 "Professional Counselors Licensing Act."** OSMA POSITION: Oppose. STATUS: Dormant.
- \*HB 1328 Oklahoma Mandatory Seat Belt Use Act.** OSMA POSITION: Support. STATUS: Senate Business & Labor Committee.
- HB 1333 "Alcoholism and Drug Dependency Treatment Insurance Act"; requiring health insurance policies to include coverage for alcohol and drug dependency treatment.** OSMA POSITION: Monitor. STATUS: Dormant.
- HB 1347 Removing exemption from licensure of hospitals under the Department of Mental Health.** OSMA POSITION: Monitor. STATUS: Dormant.
- \*HB 1359 Authorizing the court to place certain children with life-threatening health problems in the custody of the Department of Mental Health.** OSMA POSITION: Support. STATUS: House General Order. Withdrawn from calendar and returned to House Human Services Committee.
- \*HB 1369 Requiring attending physicians to examine newborn infants for numerous birth defects; requiring reports to be filed with State Department of Health.** OSMA POSITION: Oppose. STATUS: Senate Human Resources Committee.
- HB 1371 "Oklahoma Health Research Act"; creating Oklahoma Health Research Commission; levying an excise tax on all health and accident insurance and life insurance direct premiums, to be deposited in the Health Research Fund.** OSMA POSITION: Support. STATUS: House Economic Development Committee. Dormant.
- HB 1374 Allowing courts to add interest on certain judgments at the rate of 15 percent per year from the date of injury.** OSMA POSITION: Actively Oppose. STATUS: Dead.
- HB 1377 Including unborn infants in definition of those covered by laws regarding wrongful death actions.** OSMA POSITION: Actively Oppose. STATUS: House Public Health. Dormant.
- HB 1378 Providing that no person shall be held civilly liable for any act or omission that results in a person being born alive instead of being aborted.** OSMA POSITION: Actively Oppose. STATUS: House Criminal Justice Committee. Dormant.
- HB 1414 Department of Occupational Licensing Act.** OSMA POSITION: Oppose. STATUS: Dormant.
- HB 1417 Authorizing the Oklahoma Capital Improvement Authority to enter into an agreement with the Commission for Human Services for the purchase of Oklahoma Memorial Hospital.** OSMA POSITION: Oppose. STATUS: House Human Services Committee. Dormant.
- HB 1443 Allows any licensed optometrist to establish one or more branch offices.** OSMA POSITION: Monitor. STATUS: House Professions and Occupations Committee. Dormant.
- HB 1491 "Equitable Mental Health Insurance Act"; requiring health insurance policies to include minimum mental health benefits.** OSMA POSITION: Support. STATUS: House Insurance Committee. Dormant.
- \*HB 1496 Immuno-augmentative Therapy Act.** OSMA POSITION: Support. STATUS: Senate Human Resources Committee.
- HB 1497 Modifying definition of disease to include acquired immunodeficiency syndrome (AIDS).** OSMA POSITION: Monitor. STATUS: House Public Health Committee. Dormant.
- \*HB 1505 Providing for a code of ethics to be adopted by the Board of Examiners of Optometrists.** OSMA POSITION: Monitor. STATUS: Amended & Passed Senate Business and Labor Committee.
- HB 1545 Prohibiting hospitals from accepting insurance payments from third-party payers, for hospital services at a reduced rate or price differential, unless all third-party payers.** OSMA POSITION: Actively Oppose. STATUS: House Public Health Committee. Dormant.
- HB 1550 "Lay Midwifery Act."** OSMA POSITION: Oppose. STATUS: House Professions and Occupations Committee. Dormant.
- HJR 1031 Directing the sale of Oklahoma Memorial Hospital to the Capital Improvement Authority.** OSMA POSITION: Oppose. STATUS: House Human Services Committee. Dormant.



## Report of the COUNCIL ON MEMBER SERVICES

Subject: **Annual Report**

Presented by: William O. Coleman, MD, Chairman

Referred to: Reference Committee

### Introduction

It is the responsibility of the Council on Member Services to monitor and develop programs that offer direct benefits to physician members of the OSMA. These include a variety of sponsored insurance programs — including the successful professional liability coverage through PLICO and PLICO's health insurance. Additionally, the Council supervises the OSMA sponsored tours and offers numerous other programs each year for members.

The Council is also charged with the responsibility of supervising and maintaining the underwriting program for professional liability insurance through PLICO. This is a contracted function between the OSMA and the PLICO management company, C.L. Frates, Inc.

### Review of Activities

*A. Workers' Compensation* — Following the 1983 annual Meeting of the OSMA House of Delegates, the Council was authorized to offer a new insurance plan to OSMA members. The Dodson Insurance Group, through its wholly-owned subsidiary, *Casualty Reciprocal Exchange*, was authorized to offer Workers' Compensation insurance to OSMA members at a reduced premium.

This OSMA sponsored insurance program continues to grow and the Council has authorized and supervised two general membership mailings during the past year. The primary purpose of both of the mailings was to remind Oklahoma physicians that state law now requires all employers to carry Workers' Compensation insurance on all employees.

*B. New Employee Seminars* — Two seminars for new medical office employees were sponsored by the Council in 1984-85. Offered in both Oklahoma City and Tulsa, the purpose of the seminars is to familiarize new medical office employees with the legal and ethical aspects of the doctor-patient relationship and to give them some background information on medical education, medical ethics, doctor-patient-hospital relationship, financing medical care, and working with patients.

The Council authorized that the seminars be repeated in late spring or early summer, 1985. OSMA Legal Counsel Ed Kelsay served as instructor for the seminars. A fee of \$50 per person was charged to offset the cost of the seminars and to pay for the educational materials that were distributed. A small profit (approximately \$800) was realized after all seminar bills were paid.

*C. Workers' Compensation Seminar* — In late 1984, the Oklahoma Workers' Compensation Court officially adopted the second edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* as its official evaluation guide. On Saturday, February 2, and Saturday, April 13, the OSMA sponsored special seminars in Oklahoma City and Tulsa to familiarize physicians with the new, expanded AMA guide.

Each seminar was actually divided into two parts, a morning session to explain the new guide and an afternoon session designed primarily for medical office personnel, dealing with the business aspects of filing and collecting Workers' Compensation claims.

Both seminar sessions were extraordinarily well attended.

In keeping with the Council's policy of only sponsoring seminars that will pay for themselves, after all bills were paid, the Workers' Compensation seminars resulted in a profit of approximately \$4,000.

*D. Computer Conference* — April 9, 1985, your Council participated in the Southwest Computer Conference in Oklahoma City by offering a half-day program on the use of computers in medical offices. The Southwest Computer Conference was actually three days long, April 9-11, in Oklahoma City's Myriad Convention Center and featured over 200 exhibits from computer hardware and software companies.

OSMA's portion was conducted on Tuesday morning by Ed Kelsay, OSMA Legal Counsel. A fee of \$35 per person was charged in keeping with the Council's policy of attempting to make each program self-sustaining.

*E. Financial Planning Seminar* — On Saturday, February 16, the Council sponsored a full-day program entitled "Increasing Your Net Worth" by the Glazer Financial Group of Dallas, Texas. Thirty-five physicians and spouses attended the program.

The seminar was extremely well received by those in attendance and the Association staff was encouraged to offer more programs on financial planning.

A registration fee of \$125 per physician (spouse included) was charged to offset the seminar cost. This seminar resulted in a small profit of slightly less than \$100.

*F. Medical Office Management Seminar* — In late March and early April the Council sponsored a series of ten full-day seminars on Medical Office Management throughout the state. The program, conducted by OSMA Legal Counsel, Ed Kelsay, was offered in Ardmore, Bartlesville, Elk City, Enid, Lawton, McAlester, Muskogee, Oklahoma City, Tulsa, and Woodward. While attendance was very good in Tulsa and Oklahoma City, four of the programs had to be cancelled because of very low registrations (2 or 3 people): Elk City, Enid, Muskogee, and Woodward. A total of 90 medical assistants attended the programs.

*G. Retirement Seminar* — The American Medical Association's seminar entitled "Gearing Up for Retirement" was offered by the Council to OSMA members on Friday, March 15, at the Lincoln Plaza Hotel in Oklahoma City.

Conducted by Karen Zupko, Program Director for the AMA's Department of Practice Management, the seminar was primarily designed for those physicians contemplating retirement within the next five to ten years.

A total of 16 physicians and their wives attended and paid a registration fee of \$125 per physician (spouse included at no charge).

This program was conducted on a "break-even" basis.

*H. Summer Seminar Series* — The Council has authorized a series of four half-day seminars each in Oklahoma City and Tulsa for August, 1985.



To be conducted by Medical-Legal Seminars, the programs will include Collecting Medical Accounts, Telephone Collecting, Medical Personnel Management, and a fourth seminar to be selected at a later date.

The Tulsa series will be offered on August 7 and 8, at Tulsa's Holiday Inn Central and the Oklahoma City series on August 14 and 15, at the Holiday Inn West.

*I. Pre-Paid Legal Services* — Although the Council determined it did not wish to "sponsor" Pre-Paid Legal Services, it did authorize a letter and promotional brochure to all Oklahoma physicians stating that this was a service that might be of interest to doctors and should be given serious consideration.

Pre-Paid Legal Services is a company headquartered in Ada, Oklahoma, offering legal service insurance, similar to health insurance, for a modest premium.

*J. AMA Audio-Medical News* — At the invitation of the American Medical Association, the Council determined it would become a distributor for the AMA's *Audio-Medical News*, a nationwide cassette tape news service designed specifically for physicians.

*Audio-Medical News* helps the physician by delivering medical news in a capsule form. Twice a month a subscribing physician receives an audio-cassette tape containing both medical and business information.

This agreement with AMA *Audio-Medical News* is that the Association will receive a 15% rebate for all subscriptions coming out of the state of Oklahoma. This should result in enough income to offset any promotion expense incurred.

*K. AMA-GTE Telenet* — In May of 1984, the OSMA Board of Trustees authorized the Council to enter into a contract to become a distributor for the American Medical Association's Telenet computerized medical information network. The network was created for the AMA by GTE and is telephone accessible from any place in the United States.

In August, 1984, the Council forwarded a signed distributorship contract to GTE. In late September, GTE told the OSMA that it was renegotiating all distributorship contracts and that new information would be out in mid-fall. When the new contract was received it was a major change from the original distributorship agreement. During the review of the new proposal, it was discovered that the AMA and GTE had entered into an agreement to waive the \$100 subscription fee being charged to physicians wanting to sign up for the program. The subscription fee was waived for all AMA members and, since Oklahoma is a unified AMA membership state, this included all OSMA members.

Without the \$100 subscription fee to offset promotional costs, it was no longer economically feasible for the Association to be a distributor for the network.

During its February meeting, the Council determined to take a "wait-and-see" position and not pursue the distributorship contract any further.

*L. Underwriting Review* — The most important function carried out by the Council on Member Services this administrative year has been the continued conduct of the annual underwriting review for the Association-owned Physicians Liability Insurance Company (PLICO).

The Underwriting Plan for PLICO requires that each year the Association's Council on Member Services review all claims, settlements, or judgments to determine whether or not there is a pattern of losses that could be prevented through the underwriting or Loss Prevention mechanism.

In addition, the Council conducted individual reviews on problem cases or to resolve underwriting difficulties whenever a physician would apply for coverage and there appeared to be an underwriting problem in the application.

At the request of the Council, the Underwriting Plan was modified by the OSMA Board of Trustees and the PLICO Board of Directors to allow the Council, whenever sitting as the Underwriting Committee, to request physicians to personally appear and explain any unusual circumstances. It is felt that this change will allow the Council to function more conveniently whenever taking on an underwriting problem.

#### *M. Endorsed Insurance Programs — Group Term Life*

The OSMA Group Term Life program offers coverage from \$25,000 to \$300,000 for the physician and his spouse, and from \$10,000 to \$100,000 for the employee of a physician. The Accidental Death benefit is available up to \$100,000 under the Group Term Life program. The combination of these gives a maximum of \$200,000 Accidental Death benefit available under the Oklahoma State Medical Association's programs.

Dependent coverage is available at \$2.00 per year for coverage up to \$2,000 for children at home. This \$2.00 per year covers all children regardless of how many children are in the family.

After a physician has been in the program for one year, he or she is eligible to convert to an Ordinary Life policy through Loyalty Life Insurance Company. We have received a manual and conversion applications from Loyalty Life and find their rates very competitive for these older ages.

We have established a pending system and contact physicians within a few months of the billing and of their birthday changes at 60, 65 and 68 to prevent the loss of coverage in cases where it is truly needed to be maintained after a physician has retired.

	1983	1984
Written Premiums	\$63,460.00	\$90,097.00
Losses Incurred	-0-	-0-

The program had approximately 6 million dollars in face amount when we assumed marketing responsibility. Today it covers 383 people for over 20 million dollars in total face amount.

#### *OSMA Sponsored Personal Umbrella Liability Program*

A Master Personal Umbrella Liability policy is written each year effective January 1 in the name of Oklahoma State Medical Association. Subsequently, individual certificates are issued to physicians requesting the coverage. Each certificate sets out the desired limit of liability running from \$1,000,000 through \$10,000,000.



Growth of this program is displayed in the following statistics:

	1982	1983	1984	1985
Number of Participants	928	958	1,010	996
*Premium	\$126,582	\$158,082	\$163,179	\$167,784

\*Major increase in premium past few years can be attributed to physicians purchasing higher limits of liability.

#### *Hospital Indemnity*

Pays a specified amount per day that an insured is a patient in a hospital. This program will pay up to 365 days benefit from \$20.00 to \$200.00 per day. It can include the member, his spouse and family. The policy does not coordinate with any other health insurance you may have, i.e., the money comes directly to you for each day of hospitalization. You could use it to pay a yardman, a housekeeper, babysitter, or to meet your deductible and co-insurance responsibilities under your group health plan. The policy is not underwritten (no health questions). It, however, provides no benefit for the first 24 months of the policy, for any health problems treated in the 12 months before the policy's effective date.

There are 184 lives on this program.

Experience is as follows:

	1981	1982	1983	1984
Written Premiums	\$12,922	\$15,185	\$14,349	\$14,418
Incurred Losses	9,940	4,903	3,020	1,660

#### *Accidental Death and Dismemberment*

This program provides benefits from \$25,000 to \$100,000 for accidental loss of life and a portion thereof for accidental loss of life and a portion thereof for accidental loss of limb, eyesight, speech or hearing.

It provides 24 hour protection wherever you go.

There are 258 lives on this program.

	1981	1982	1983	1984
Written Premiums	\$6,414	\$6,944	\$6,392	\$6,137
Incurred Losses	-0-	-0-	25,000	25,000
Loss Ratio			391.1%	407.9%

#### *GXM-X Disability Income*

At this time we have 435 lives on this program. Each six months we drop those physicians who have turned 70 years of age.

Experience is as follows:

	1981	1982	1983	1984
Written Premiums	\$135,017	\$161,612	\$166,262	\$178,495
Incurred Losses	191,251	67,017*	-0-	83,072
Ratio		41.5%*	-0-	46.5%

\*due to release of claim reserves

There are three benefit levels within the program, all begin the benefit period with the first day of an accident and eighth day of sickness.

*Plan L-65* — Accident benefits payable for lifetime. Sickness benefits payable to age 65 or for a two-year maximum period if the disability begins between the 63rd and 70th birthdays. Benefits are payable based on being unable to perform the substantial and material duties of your regular occupation.

*Plan L-7* — Accident benefits payable for lifetime. Sickness benefits payable for a 7-year maximum period, but not beyond age 65; for a two-year maximum period if disability begins between the 63rd and 70th birthdays. Benefits are payable based on being unable to perform the substantial and material duties of your regular occupation.

*Plan 5-2* — Accident benefits payable for a 5-year maximum period. Sickness benefits payable for a 2-year maximum period. Benefits payable based on being unable to perform the substantial and material duties of your occupation.

The waiting period may be extended, which in turn reduces the premiums.

Included as additional features are:

1. \$1,000 Accidental Death Benefit
2. Pays 100 to 200 times the selected weekly indemnity for accidental loss of limbs, sight, speech, and hearing as scheduled in the policy.
3. Covers physicians' fees for treatment for non-disabling injuries, to a maximum of the amount of one week's indemnity provided no other indemnity is payable for such injury under the policy.
4. Premium payments will be suspended, while the policy is in force and prior to age 60, after you receive total disability benefits for six continuous months. Waiver of Premiums continues as long as you continue to receive benefits.
5. Pays a minimum lump sum amount for specific fractures and dislocations.
6. Benefits are payable regardless of other insurance.

Options under this program are:

*Cost of Living Increase* — This new feature is automatically added to all newly issued policies for applicants under age 45 who have fully satisfied the Company's underwriting requirements. It can add approximately 10% to your monthly benefits each year until your monthly benefits reach the option maximum of \$4,000.00. You may exercise such option without further underwriting at any of the anniversary dates prior to age 50. You will be notified of its availability on each of the anniversary dates and also of the premium charge for the increase available. You may accept or reject the offer as you see fit.

*Optional Recovery Benefit Rider* — Once you return to work on a full- or part-time basis, and no longer qualify for regular weekly indemnity benefits, the Company will pay a lump sum benefit equivalent from 1/4 to 3 months disability payments, depending on the length of your disability as per the schedule:

If your disability for which indemnity is payable lasted at least:

	Benefit Payable
45 days	1/4 months benefit
3 months	3/4 months benefit
9 months	2 1/4 months benefit
12 months	3 months benefit

**Residual Disability Benefit** — Residual Disability is a condition whereby: (1) You are unable to perform one or more of the substantial and material duties of your occupation; or (2), are unable to perform all of the substantial and material duties of your occupation for as much time as is normally required. (3) You are not totally disabled. (4) You are under the care of a duly licensed physician, other than yourself, and (5) you suffer a continuous loss of at least 20% of your prior monthly income.

*Office Overhead Expense Program*

Physicians see sick and injured people every day. Some of these people are disabled, needing time to heal.

But healing time is costly time. Many suffer the side effects of financial hardship from their loss of earned income.

For self-employed professionals, such as physicians, healing time creates even more disorders. Not only has the income ceased, but overhead expenses continue. Rent, utility and payroll expenses must still be met even though earnings have ceased. These expenses might be met from savings. Paying overhead for a month or two is one thing, but suppose the physician is disabled for a year or more? Why should long-term financial plans be disrupted when it's not necessary?

Prevent this financially debilitating situation with the Open Door policy. If you are totally disabled by either sickness or injury, the remedy pays benefits to cover up to 100% of your office overhead expenses.

This plan features:

**Big Benefits** — You choose your benefits to fit your needs. Benefits are available in \$100 increments up to \$5,000 a month maximum.

**Lingering Coverage** — You receive benefits while you are totally disabled, up to 18 months.

**Tax Relief** — Premiums paid for the Open Door policy are generally a tax-deductible business expense. Benefits used to pay overhead are generally tax deductible.

**Flexibility** — You choose when payments start: either 15 days or 30 days after disability begins.

There are 240 lives on this program.

Experience as follows:

	1981	1982	1983	1984
Written				
Premiums	\$42,219.45	\$51,540.31	\$62,235.48	\$80,243.28
Paid				
Claims	1,500.00	4,446.66	2,350.00	10,500.00
Loss Ratio	- 1.3%	17.4%	14.5%	11.5%

**N. Vantage Travel** — For many years, the Association has sponsored tours through the Intrav Corporation (see "Sponsored Tours" below). While it intends to continue to do so, a proposal was received from the Vantage Travel Company for a mid-fall tour to Australia.

The Vantage Travel Company was formed by a group of travel experts that have worked for Intrav and several other companies specializing in medical tours. The tour format is basically the same, but is touted as being "more personal" since the tour groups are smaller.

All expenses for promoting the Vantage Tour to Australia will be recovered by the Association.

**O. Sponsored Tours** — Intrav is one of the most respected tour operators in the world. The OSMA has utilized the Intrav Corporation for sponsored tours for many years and is extremely well satisfied with the company's professionalism. It works primarily with professional associations representing medical doctors, bankers, lawyers, CPAs, etc.

The OSMA recovers all of its expenses for promoting tours from Intrav Corporation and is thus able to make them available to physician members at no cost to the Association. One of the interesting things about the Intrav tours is that they are made up from several different states and usually contain an excellent cross-section of other professionals.

In 1984-85 the Association sponsored or is sponsoring the following tours:

*1984*

Dutch Waterways (June)  
Orient Express Adventure (July)  
Europe/Oberammergau Passion Play (July)  
Mediterranean/Greek Islands Air/Sea Cruise (Sept.)  
Danube River Adventure (October)  
Virgin Islands Yacht Cruise (December)

*1985*

Cairo/Kenya (January)  
Rocky Mountains (May)  
Scandinavia (June)  
Waterways and French Chateaux (July)  
British Isles (July)  
New England/Cape Cod (July)  
Alaska/Canada (July)

**P. Fiscal Note** — As stated in the above report, it is the Council's policy to attempt to make each of its programs self-sustaining. However, there are some Council activities that do require expenditures. It's estimated that the Council will need a budget of approximately \$1,500 allocated for 1985-86.

Respectfully submitted,  
William O. Coleman, MD, Chairman  
Richard McKinne, MD, Vice Chairman  
Nolen L. Armstrong, MD  
William G. Bernhardt, MD  
Tim S. Caldwell, MD  
Jack T. Dancer, MD  
E. Edwin Fair, MD  
Wilfred S. Gauthier, MD  
Joe Ray Hamill, MD  
Joe S. Hester, MD  
George H. Jennings, MD  
Edward A. McCune, MD  
Robert A. McLauchlin, MD  
Francis D. Oakes, MD  
Paul O. Shackelford, MD  
S. Fulton Tompkins, MD



## Report of the OKLAHOMA MEDICAL POLITICAL ACTION COMMITTEE

Subject: **Annual Report**

Presented by: John A. McIntyre, MD, Chairman

Referred to: Reference Committee III

### Introduction

The Oklahoma Medical Political Action Committee is a voluntary, unincorporated entity made up of individual physicians and others interested in helping political candidates get elected to office and share a similar political philosophy. OMPAC is an independent and autonomous organization managed by a Board of Directors. The Board of Directors has control over the policies and activities of the committee and serve without compensation. The OMPAC Board meets annually to conduct business of the committee and otherwise meets several times during an election year to distribute OMPAC funds to candidates.

### Review of Activities

The OMPAC Board of Directors, under the able leadership of William M. Leebron, MD, Chairman, held three meetings in 1984, prior to each of the major political elections. All of the decisions made during these meetings were based on a combination of information obtained by individual Board members, as well as, compiled information from OMPAC members and voting records. In 1984, OMPAC expended \$42,050.00 and had a winning percentage of 85% in those races endorsed by OMPAC. The present

carryover balance from 1984 is \$14,516.18. Dr. Leebron was instrumental in bringing more members into OMPAC than in any previous year. The membership in OMPAC for 1984 was 744 and we are well on our way to increasing our membership for the 1985-86 election year. Presently OMPAC has 459 total members with 13 being 200 Club members, 14 being 99 + Club or Sustaining members and 432 being \$50.00 or Regular members. Unfortunately, the total membership in OMPAC is not very good in comparison to the number of physicians and auxiliary members presently members in the Oklahoma State Medical Association. The OMPAC Board of Directors is still challenged with efforts to increase membership. The direct financial support of candidates is a vital part of the OMPAC election year plan, but the cornerstone of the OMPAC program has been to encourage the active personal participation of physicians in political campaigns. The power of government over the lives of physicians and their practices has never been greater, and the average physician must look to OMPAC and AMPAC to represent them effectively in political campaigns, in the halls of Congress, and the Oklahoma State Legislature. OMPAC is the voice of medicine in politics. OMPAC is also our action arm. Our means of getting into campaigns and assisting candidates who we can elect and work with in the future for the betterment of medicine. On behalf of the OMPAC Board of Directors, all OSMA members are encouraged to join OMPAC and current OMPAC members are encouraged to upgrade their membership.

Respectfully submitted,  
John A. McIntyre, MD, Chairman



At the annual Past Presidents' Breakfast, Ed Kelsay (standing), OSMA legal counsel, fields questions.

## Report of the PHYSICIAN RECOVERY COMMITTEE

Subject: **Annual Report**

Presented by: Ted Clemens, Jr., MD, Chairman

Referred to: Reference Committee III

The Physician Recovery Committee is pleased to report enormous progress during the past year.

In August, 1984, J. Darrel Smith, MD, Moore, agreed to serve as interim medical director of the program.

Since then the committee is actively working with 30 physicians who have completed or are undergoing treatment and rehabilitation.

The Committee serves as an advocate for physicians with dependency problems. Its work is conducted in complete confidence.

National statistics indicate that ten percent of physicians experience chemical or alcohol dependency. In Oklahoma, that means over 400 physicians still need to be reached.

The critical goal for the Committee this year will be to expand the scope of the program and secure an adequate funding base for the program.

Physician recovery programs run by volunteers and funded by random contributions are historically unsuccessful.

Successful programs have worked with professional liability insurers, foundations and pharmaceutical companies to secure adequate and ongoing funding.

In order to expand the scope of the program the Committee plans to produce a brochure explaining the program to physicians; increase presentations to local medical societies and hospital medical staffs; establish a telephone hotline dedicated solely to the Physician Recovery Committee; and purchase videotapes, books and pamphlets for use by the Committee and impaired physicians.

The proposed budget is submitted to the OSMA Board of Trustees for approval:

Program Director	
(physician, one-third time) . . . . .	\$40,000.00
Travel (in-state and professional meetings) . . . . .	4,500.00
Printing (brochure) . . . . .	2,500.00
Dues . . . . .	100.00
Audiovisuals/books . . . . .	1,000.00
Clerical support . . . . .	1,000.00
Telephone hotline . . . . .	300.00
<b>TOTAL</b>	<b>\$49,400.00</b>

Respectfully submitted,  
Ted Clemens, Jr., MD, Chairman  
Homer V. Archer, MD  
Macaran Baird, MD



C.S. Lewis, Jr., MD, Tulsa, past president of OSMA and president-elect of the American College of Physicians (ACP), looks up from his delegate handbook during a House session.

Luis A. Barrios, MD  
Theodore J. Brickner, Jr., MD  
Donald L. Cooper, MD  
Raymond L. Cornelison, Jr., MD  
Jimmy C. Couch, MD  
Marcus L. Cox, MD  
Carl F. Critchfield, MD  
Frank Crowe, MD  
David V. Eakin, MD  
Robert G. Ellis, MD  
Donald C. Karns, MD  
Thomas S. Llewellyn III, MD  
George C. Moore, MD  
William T. Morris, MD  
Donald Reid, MD  
James R. Rhymer, MD  
Michael Sandlin, MD  
Charles J. Shaw, MD  
J. Darrel Smith, MD  
Joseph W. Stafford, MD  
Rhonald L. Whiteneck, MD  
V. William Wood, MD  
M. Michael Sulzycki, OSMA Staff





Elvin M. Amen, MD, (left) OSMA president for 1985-86, thanks his predecessor, James B. Eskridge III, MD, for his leadership and service as he presents a plaque of appreciation from the entire membership.

## RESOLUTION 2

(Adopted)

Introduced by: Tulsa County Medical Society  
Subject: **Proposed User Fee for Tobacco Products**  
Referred to: Reference Committee III

WHEREAS, The direct relationship between cigarette smoking and cancer of the respiratory system and coronary artery disease has been scientifically proven by responsible research; and

WHEREAS, Cigarette smoking is the most common cause of preventable cancer; and

WHEREAS, Approximately one-third of all cancer deaths are caused by smoking; and

WHEREAS, One-fourth of all Medicaid and Medicare costs are the result of smoking; and

WHEREAS, The federal government has to spend large amounts of its resources on the treatment of patients with smoking-induced diseases; and

WHEREAS, The higher costs of hospitalization paid by the non-users of tobacco because of the costs of hospitalization due to smoking-induced illness is a form of discrimination; and

WHEREAS, There are precedents for user fees, such as taxes on gasoline to build and maintain roads, and the sales of hunting fishing licenses to finance game wardens and fisheries; and

WHEREAS, It costs one and one-half cents per cigarette for tobacco-related illnesses and approximately two and one-half cents per cigarette for lost productivity; and

WHEREAS, It is important that the federal government be aware that medical societies are undertaking positive action against the hypocrisy of tobacco subsidies; now therefore be it

*Resolved*, That the Oklahoma State Medical Association encourage the Oklahoma State Legislature to enact legislation imposing a user fee on tobacco products for the purposes of treating smoking-induced illnesses and conducting related scientific research.

## RESOLUTION 9

(Adopted)

Introduced by: Tulsa County Medical Society  
Subject: **Opposition to Hospital Pre-Admission Certification**  
Referred to: Reference Committee III

WHEREAS, The medical profession has a major responsibility in the protection of the health of the public; and

WHEREAS, The physician/patient relationship is vital to the physical and emotional health of the patient; and

WHEREAS, Only a personally involved physician can understand the ramifications of a patient's illness and his or her needs for certain types of treatment and/or hospitalization; and

WHEREAS, The rationing or limiting of health care to the public has not been accepted in the United States; and

WHEREAS, The concept of hospital pre-admission certification is antagonistic to all of the above respected concepts; now therefore be it

*Resolved*, That the Oklahoma State Medical Association take a public stand against the requirement for hospital pre-admission certification by government, industry, and private health insurance carriers, and explain the dangers of such requirements to the public; and be it further

*Resolved*, That the Oklahoma State Medical Association influence the American Medical Association to take a similar policy position.

## RESOLUTION 11

(Adopted)

Introduced by: Oklahoma Delegation to the AMA  
Subject: **Federal Regulations**  
Referred to: Reference Committee III

WHEREAS, A steady stream of rules, regulations, and decisions continues to originate within various local, state, and federal agencies; and

WHEREAS, These rules, regulations and decisions are usually attributed to a large agency such as HHS, FTC, FCC, etc.; and

WHEREAS, Within these organizations there are people with names who are responsible for the rules, regulations, and decisions originating within organizations; and

WHEREAS, In the absence of these names, it is very difficult, and many times impossible, to identify the person or persons to whom proper accolades, congratulations, or other appropriate responses should be addressed; and

WHEREAS, The individuals, and not the organizations, should reap the appropriate rewards for such rules, regulations, and decisions; now therefore be it

*Resolved*, That all publications, and radio and television newscasts should always include the names of the individuals of these organizations who are responsible for these rules, regulations and decisions; and be it further

*Resolved*, That all individuals and other organizations which are affected by these rules, regulations and decisions, make the appropriate response known to those individuals within these organizations who are responsible for the rules, regulations, and decisions; and be it further

*Resolved*, That this resolution be circulated to all news media and publications.

## RESOLUTION 12

(Adopted)

Introduced by: East Central Oklahoma County  
Medical Society

Subject: **Liability Insurance Carriers**

Referred to: Reference Committee III

WHEREAS, Oklahoma law does not currently require liability insurance carriers to honor a standard assignment of benefits between a patient and a physician, although health insurance carriers are required to honor such assignments; and

WHEREAS, Physicians often find that liability insurance carriers are settling claims, paying the patient directly, and the patient is then failing to pay outstanding medical bills; and

WHEREAS, Medicare, under recent changes of the federal law, is now the secondary payor whenever there is another insurance, available such as that which would be involved in a personal liability situation; now therefore be it

*Resolved*, That the Oklahoma State Medical Association seek appropriate amendments to Oklahoma law that would require liability insurance carriers to honor the usual standard assignment of benefit to the physician whenever the patient is willing to assign such benefits and the physician is willing to accept assignment.

## RESOLUTION 13

(Adopted)

Introduced by: East Central Oklahoma County  
Medical Society

Subject: **Liens against Insurance Proceeds**

Referred to: Reference Committee III

WHEREAS, Physicians frequently treat patients that are involved in litigation against third parties in which medical payments are part of a judgment or an insurance settlement; and

WHEREAS, Frequently these judgments and settlements are paid directly to the patient and the medical bills are never resolved or settled; and

WHEREAS, Under the present law physicians have no way to protect their charges; now therefore be it

*Resolved*, That the Oklahoma State Medical Association seek legislation that would allow physicians to file a lien in some appropriate manner against insurance proceeds, settlements, or judgments similar to that allowed Oklahoma hospitals under the hospital lien statutes.

Late Resolution

## RESOLUTION 19

(Adopted)

Introduced by: OSMa Board of Trustees  
Subject: **HCFA Demonstration Project**  
Referred to: Reference Committee III

WHEREAS, In 1982 the OSMa House of Delegates passed Resolution No. 9, urging the Health Care Financing Administration to eliminate the five Medicare reimbursement areas in Oklahoma and to establish one statewide reimbursement profile for Oklahoma physicians; and

WHEREAS, In 1983 the AMA House of Delegates, through its Council on Medical Services, conducted two exhaustive studies on physician reimbursement (CMS Report D A-83 and CMS Report B I-83) and concluded that the AMA "... recognizes the validity of a pluralistic approach to third-party reimbursement methodology, and that indemnity reimbursement as well as usual, customary, or reasonable have positive aspects which merit further in-depth study"; and

WHEREAS, The OSMa House of Delegates in 1984 passed Resolution No. 6, calling for support of the concept that physicians engaged in diagnostic evaluation and therapeutic management of patients are entitled to more equitable reimbursement; and

WHEREAS, These actions and studies have made no significant impact on third-party reimbursement to physicians; and

WHEREAS, Senator Don Nickles has secured from HCFA a tentative commitment to consider an Oklahoma demonstration project on alternative physician reimbursement proposals under Medicare; and





With his wife, Lucile, beside him, a confident President Amen begins his term in office.

WHEREAS, Such a demonstration project could identify a better methodology for paying physicians, providing there was sufficient flexibility in developing reimbursement levels, and the fear of FTC and Justice Department sanctions could be allayed; now therefore be it

*Resolved*, That the OSMA Board of Trustees, through its appropriate councils, is hereby authorized to negotiate with HCFA for approval of a demonstration project to develop a more equitable method of paying physicians under Medicare, providing the project is not required to be budget neutral, that adequate assurances from affected government departments can be secured, that no adverse actions will accrue to OSMA as a result of the project.

Late Resolution  
**RESOLUTION 20**  
(Adopted)

Introduced by: William O. Coleman, MD, Oklahoma City  
Subject: **Funding of Medical Education Through Medicare**  
Referred to: Reference Committee III

WHEREAS, The funding of medical education may be one of the most important issues facing American medicine today; and

WHEREAS, In view of the financial crisis facing the Medicare program, the Advisory council on Social Security-Medicare Benefits and Financing (1982) concluded: "That this involvement of the Medicare program in underwriting these costs is inappropriate since the program is designed to pay for medical services for the elderly, rather than to underwrite the costs of training and medical education"; and

WHEREAS, The Advisory Council calculated, "If Medicare funding for these training programs could be withdrawn by 1987, total program savings through 1995 could eliminate up to 20% of the projected Medicare trust fund deficit. In dollar amounts, savings to the trust fund would be \$40.8 billion through 1995"; and

WHEREAS, The elimination of this educational funding through Medicare could immediately increase the amount of available funds for health care to the elderly and could change the character of Medicare toward a standard health care plan, subject to contract and other negotiation as any other health care plan; and

WHEREAS, AMA policy continues to actively promote to the Congress and Executive Branch the continuing maintenance of indirect medical education funding at the level prescribed by the Social Security Amendments of 1983; now therefore be it

*Resolved*, That the OSMA petition the AMA, through its House of Delegates, to recognize and accept the necessity for the removal of medical education funding from Medicare; and be it further

*Resolved*, That the funding of medical education should be continued through an appropriate federal agency as determined by Congress.

Late Resolution  
**RESOLUTION 21**  
(Adopted)

Introduced by: Council on Planning and Development  
Subject: **Professional Liability Insurance**  
Referred to: Reference Committee III

WHEREAS, The cost of professional liability insurance for physicians has escalated precipitously in the past decade; and

WHEREAS, Insurance rates in some states are so high that certain specialties are curtailing their professional practice, to the detriment of patients; and

WHEREAS, The number of claims being filed is disproportionately high with as many as 50% being ruled non-meritorious; and

WHEREAS, Jury awards are ever-increasing with some judgments appearing excessive when compared to actual damages sustained by the plaintiff; and

WHEREAS, attempts at tort reform have largely fallen on deaf ears at the Oklahoma legislature; and

WHEREAS, the existing adjudication system for resolving professional liability issues is lengthy, expensive, and seldom pays the deserving plaintiff with more than 50% of the jury award; now therefore be it

*Resolved*, That the Oklahoma State Medical Association hereby petitions the Oklahoma Bar Association to participate in the creation of a joint medical-legal task force to study the problems of professional liability in Oklahoma and make specific recommendations to both organizations as to actions that will alleviate this worsening situation.

# INDEX to the Proceedings of the 1985 OSMA Annual Meeting

Closing Session, Minutes .....	241	President, Report of the .....	234
Opening Session, Minutes .....	237	President-Elect, Report of the .....	235
Reports, Committee, Council, and Special ....	247	Secretary-Treasurer, Report of the .....	250
Ad Hoc Committee on OSMA/OFPR Relations,		<b>Resolutions</b>	
Report of the .....	280	1 — Ending Tobacco Subsidies .....	284
Board of Trustees, Report A .....	258	2 — Proposed User Fee for Tobacco Products .	298
Board of Trustees, Report of the .....	247	3 — Prohibition of Smoking in Patient Areas .	284
Board of Trustees, Supplemental		4 — Outpatient Psychiatric Services .....	264
Report of the .....	248	Substitute Resolution .....	264
Committee on Appropriations and Auditing,		5 — Mental Health Programs .....	284
Report of the .....	257	6 — University of Oklahoma Tulsa	
Constitution and Bylaws Committee,		Medical College .....	265
Report of the .....	259	7 — Truth in Advertising .....	285
Council on Governmental Activities,		8 — Increased Professional Support	
Report of the .....	287	of OMPAC .....	265
Council on Hospital Medical Staffs,		Substitute Resolution .....	266
Report of the .....	272	9 — Opposition to Hospital Pre-admission	
Council on Long-Range Planning and		Certification .....	298
Development, Report of the .....	258	10 — Radial Keratotomy .....	285
Council on Medical Education,		11 — Federal Regulations .....	298
Report of the .....	268	12 — Liability Insurance Carriers .....	13A
Council on Medical Services, Report of the ..	271	13 — Liens Against Insurance Proceeds .....	13A
Council on Member Services, Report of the ..	292	14 — Impaired Physicians .....	265
Council on Professional and Public Relations,		15 — OMPAC Membership .....	265
Report of the .....	267	Substitute Resolution .....	266
Council on Public and Mental Health,		<b>Resolutions, Late</b>	
Report of the .....	267	16 — Reactivation of Fee Review	
Council on State Legislation, Report of the ..	289	Committee .....	286
Journal of the Oklahoma State Medical		17 — For-Profit Service Corporation .....	266
Association, Report of the .....	283	18 — PLICO Appeal Mechanism .....	266
Oklahoma Foundation for Peer Review,		19 — HCFA Demonstration Project .....	13A
Report of the .....	272	20 — Funding of Medical Education	
Oklahoma Medical Political Action		Through Medicare .....	14A
Committee (OMPAC), Report of the .....	296	21 — Professional Liability Insurance .....	14A
OSMA Auxiliary, Report of the .....	264	<b>Resolutions, Memorial</b>	
Physician Recovery Committee,		Mrs Dee Hampton .....	245
Report of the .....	297	William M. Leebron, MD .....	246
Physicians Liability Insurance Company		Bill McCabe .....	246
(PLICO), Report of the .....	262		

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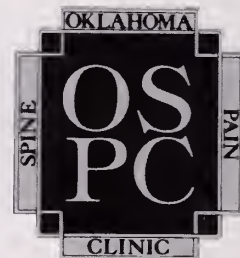
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## INDEX TO ADVERTISERS

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The Arthritis Clinic .....	28A
Ayerst Laboratories ( <i>Inderal LA</i> ) .....	18A-20A
Bank of Oklahoma .....	7A
City of Faith .....	1A
Cobblestone Park .....	231
Curtis 1000 Information Systems .....	4A
Dista Products ( <i>Keflex</i> ) .....	11A
Edmond Medical Plaza .....	229
C. L. Frates & Co., Inc. ....	226
Glass-Nelson Clinic .....	26A
Harsha Orthopedic, Inc. ....	30A
Marion Laboratories ( <i>Cardizem</i> ) .....	5A, 6A
McAlester Clinic .....	26A
Medical Arts Clinic of Ardmore .....	27A
Medical Arts Laboratory .....	24A
Mid-America Computing, Inc. ....	227
James B. Morris II & Associates .....	10A
Northwest Medical Clinic .....	30A
Oakdale Farm .....	2A
Oklahoma Allergy Clinic .....	29A
Oklahoma Cardiovascular and Thoracic Surgery Associates .....	23A
Oklahoma City Clinic .....	1FC
Oklahoma Diagnostic Imaging, Ltd. ....	22A
Oklahoma Hand Surgery Center, Inc. ....	29A
Oklahoma Lung Function Laboratory .....	29A
Oklahoma Plastic and Reconstructive Surgeons, Inc. ....	30A
Oklahoma Urology Center .....	30A
Orthopedic & Arthritis Center .....	27A
Orthopedic Associates .....	28A
OSMA Council on Member Services .....	16A
PLICO .....	35A
Rehabilitation Institute of Oklahoma .....	223
Roche Products, Inc. ( <i>Limbitrol</i> , <i>Dalmane</i> ) .....	8A-10A, IBC, BC
Shawnee Medical Center Clinic, Inc. ....	25A
Southern Plains Medical Center, Inc. ....	25A
Timberlawn Psychiatric Hospital .....	24A
Tulsa Adjustment Bureau, Inc. ....	220
The Upjohn Company ( <i>Motrin</i> ) .....	17A
Waldrop Bros., Inc. ....	224
Willow View Hospital .....	21A
Woodside Capital Corporation .....	10A

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### News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc., are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

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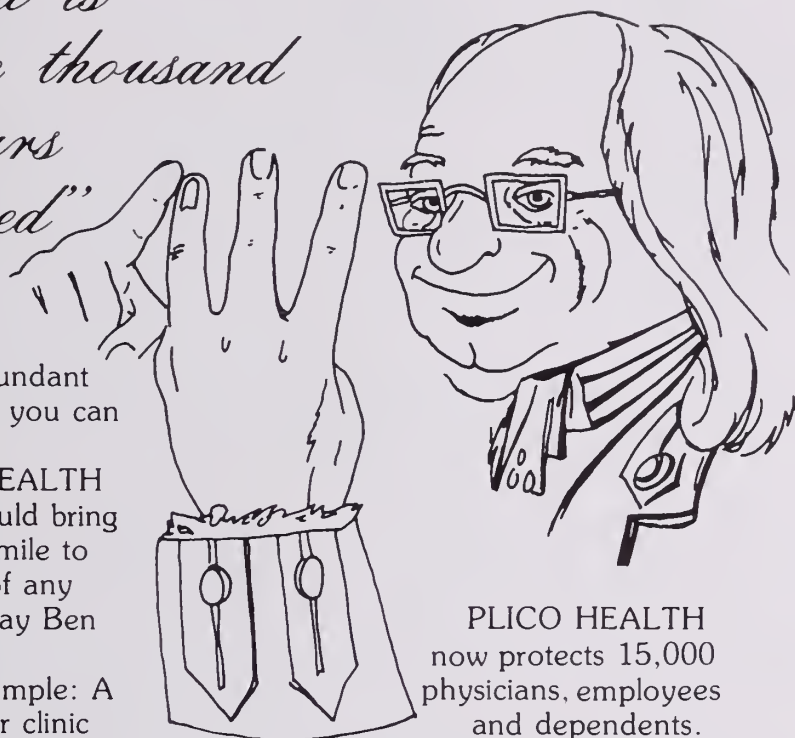
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■ (405) 691-7318 is the number of the new OSMA Physician Recovery Hotline. Physicians concerned about a drug dependency problem, whether their own or a colleague's, are urged to call this number for confidential help from other physicians.

■ July 31 is the *last day* for OSMA members to pay their 1985 OSMA and AMA dues. Memberships not paid by that date will be terminated, in accordance with association bylaws. Questions about dues should be directed to OSMA headquarters or to the secretary of your county medical society.

■ "Doctors Sunday" on the Lifetime Medical Television cable network will soon be adding a half-hour "Specialty Update in Cardiology." The American College of Cardiology (ACC) and the network have agreed to produce the monthly series on cardiovascular disease for distribution through the cable network and, eventually, through videocassette. Other specialties already included in "Doctors Sunday" are rheumatology, internal medicine, and obstetrics and gynecology.

■ The National Institutes of Health (NIH) have released a new consensus report, "Limb-Sparing Treatment of Adult Soft-Tissue Sarcomas and Osteosarcomas." Free single copies of the statement are available from Michael J. Bernstein, Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 216, Bethesda, MD 20205.

■ A special Task Force on Professional Liability and Insurance, formed by the AMA, has published a series of reports under one cover entitled *Professional Liability in the 80s*. The task force was assigned to attack the problem of burgeoning claims and lawsuits against physicians and hospitals and to search for solutions. To receive a single complimentary copy of the publication, write to the Office of General Counsel, American Medical Association, 535 North Dearborn Street, Chicago, IL 60610.

■ Readers of the OSMA JOURNAL are encouraged to submit items for publication in THE LAST WORD. Any news of people, places, and things of interest to professional colleagues across the state is welcome. (Where timeliness is a factor, however, please remember that the JOURNAL has a lead time

of about six weeks.) Correspondence should be directed to the OSMA JOURNAL, 601 Northwest Expressway, Oklahoma City, OK 73118.

■ A hypothesis that variations in the chemical environment in fetal life strongly influence behavior appears in the *May Archives of Neurology*. The late Norman Geschwind, MD, and Albert M. Galaburda, MD, of Harvard Medical School, point out that more men than women commonly are left-handed, suffer language disorders such as stuttering and dyslexia, and are subject to immune disorders. They postulate that fetal formation of the testes and secretion of testosterone influences brain hemisphere development and certain behavioral phenomena associated with the male sex.

■ Needle localizations of mammographically suspicious breast lesions is a safe, rapid, and accurate method for localizing small, potentially highly curable breast cancers with minimal sacrifice of breast tissue, according to a report in the *May Archives of Surgery*. Roger Bigelow, MD, and colleagues from the William Beaumont Hospital-Troy in Troy, Mich, report using a "hook-wire method" to localize lesions in 133 patients with suspicious but nonpalpable breast masses. Cancer was found in 24 patients. An additional 67 demonstrated calcification, and of these 16 turned out to have malignancies. "Eighty percent of the cancers were less than 1 cm in diameter, and 38% met the criteria of minimal carcinoma," the researchers report.

■ A report in the *May American Journal of Diseases of Children* suggests that daily drinking of apple juice may be a cause of chronic nonspecific diarrhea (CNSD). "We have recently encountered a subset of children with CNSD in whom nonexcessive apple juice intake seemed to cause their diarrhea," say Jeffrey S. Hyams, MD, and Alan M. Leichtner, MD, from the University of Connecticut Health Center in Farmington. Five of the children showed significant carbohydrate malabsorption after drinking 240 mL (about one 8 oz glass) of apple juice. "Withdrawal of apple juice from the diets of these subjects was curative in all cases," they say. Before embarking on a time-consuming evaluation for CNSD in otherwise healthy children, they recommend a brief restriction of apple juice intake.

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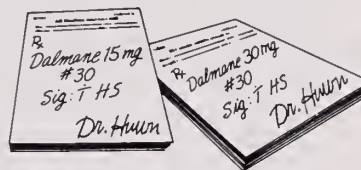
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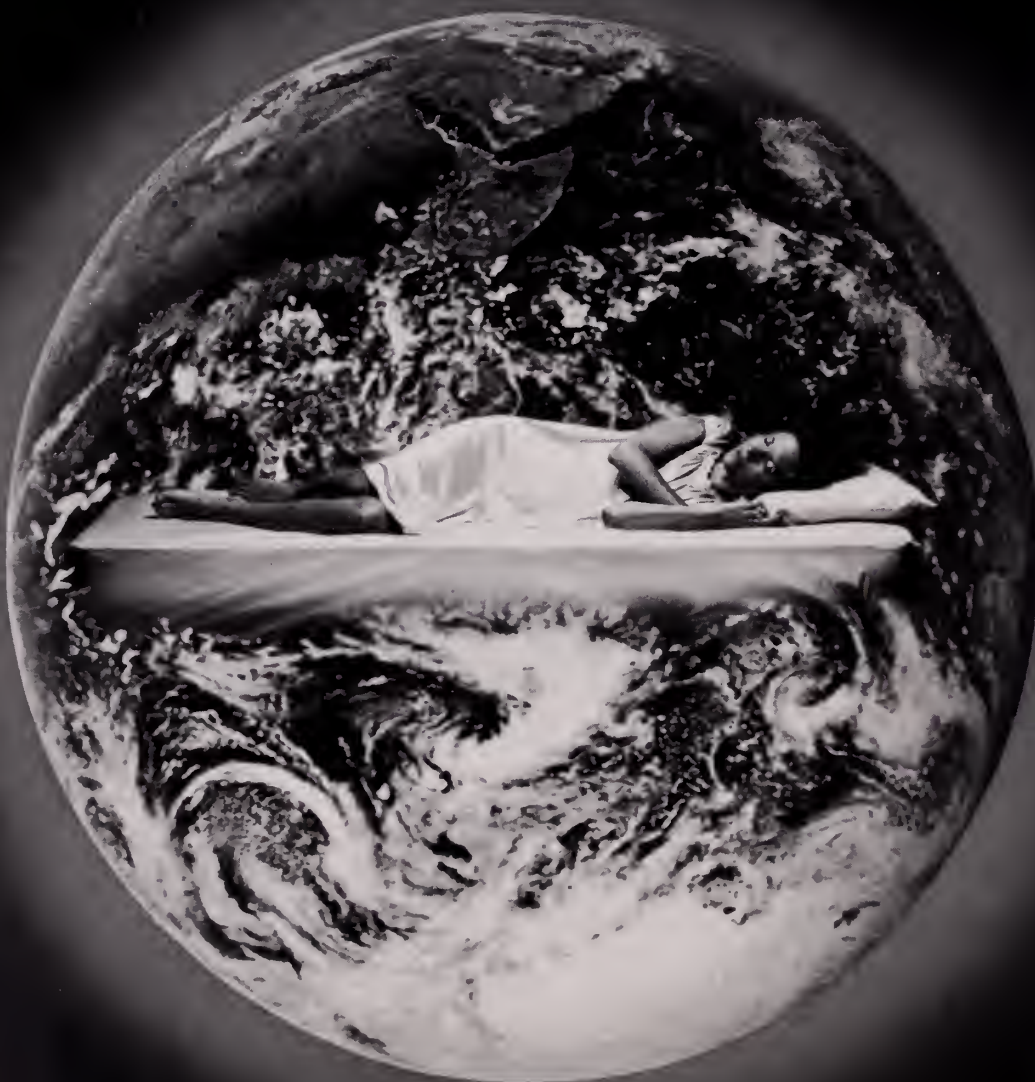
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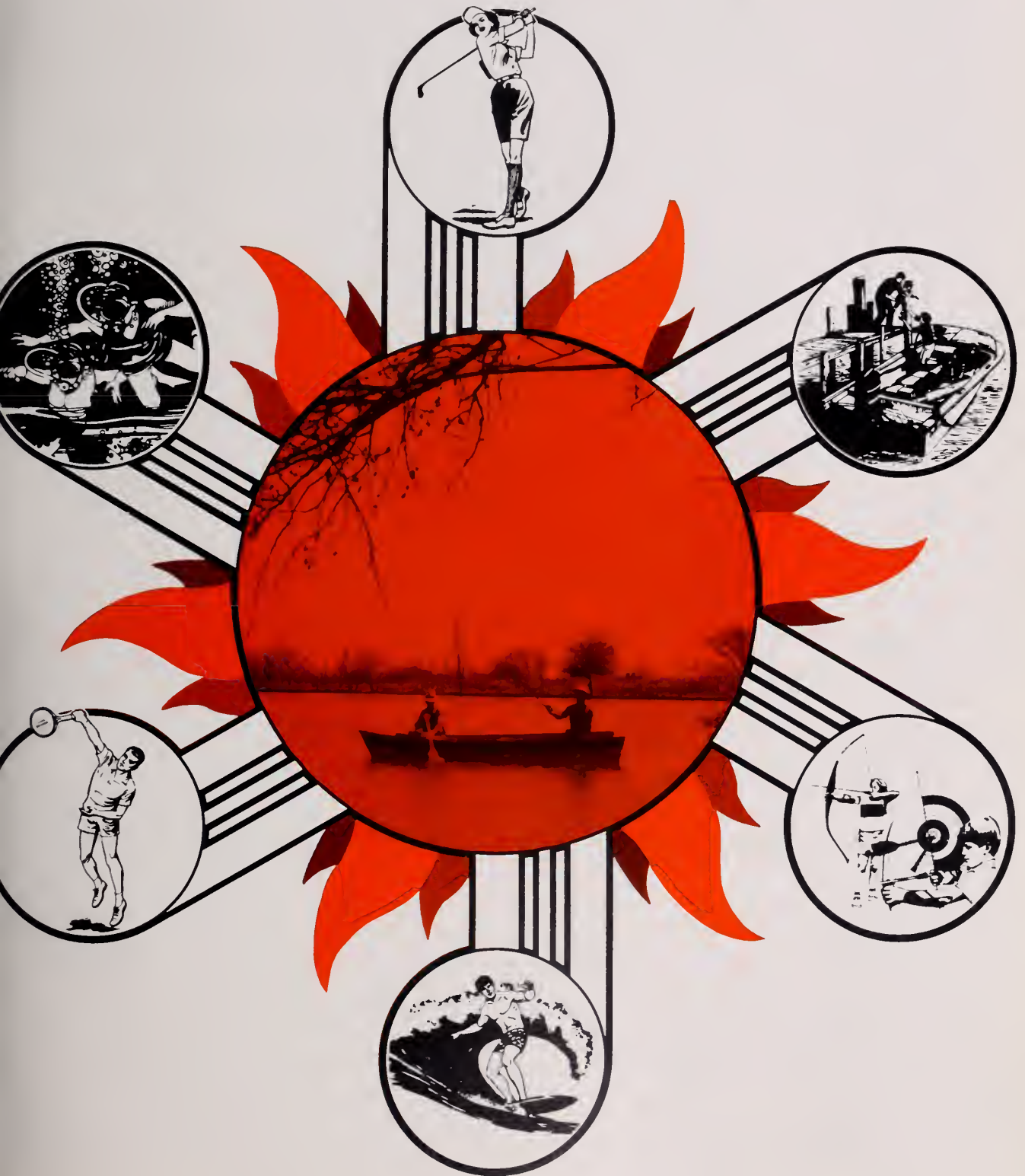
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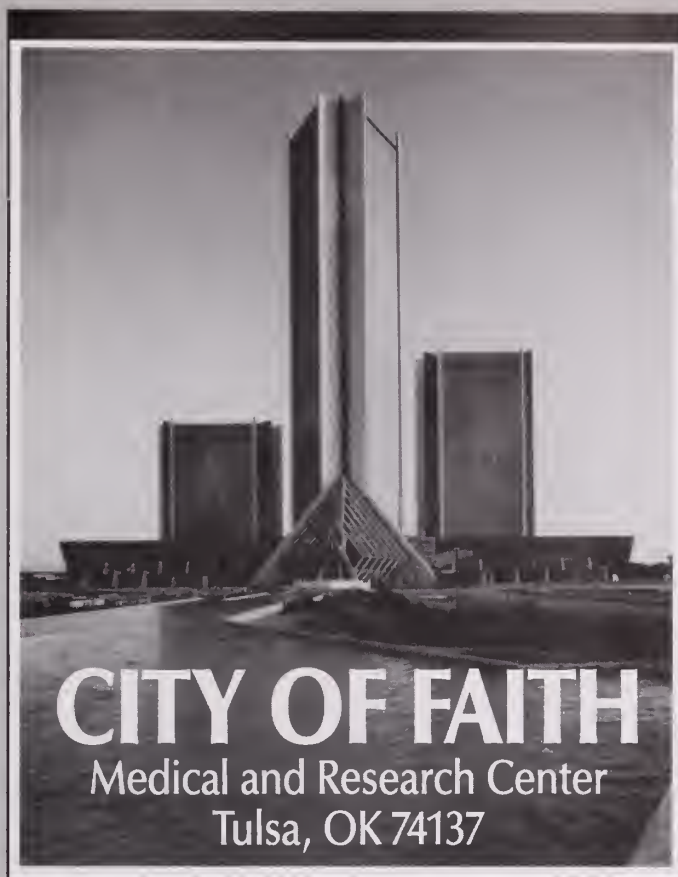
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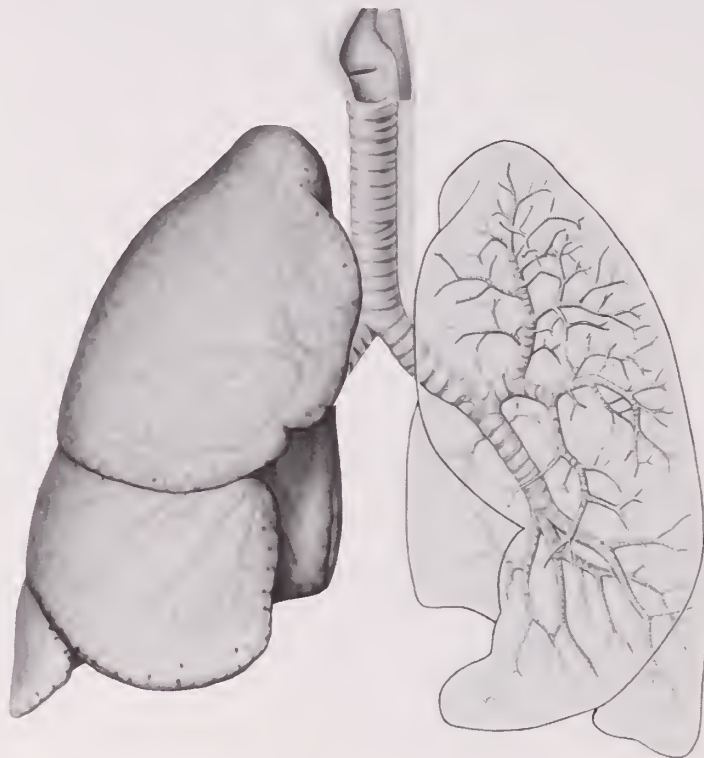


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#### Brief Summary Consult the package literature for prescribing information

**Indications and Usage** Cecilor<sup>®</sup> (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cecilor.

**Contraindication** Cecilor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cecilor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics including macrolides, semisynthetic penicillins, and cephalosporins; therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, manage-

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

**Precautions:** General Precautions — If an allergic reaction to Cecilor<sup>®</sup> (cefactor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cecilor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cecilor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended. As a result of administration of Cecilor, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> Glucose Enzymatic Test Strip, USP, Lilly.

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

**Usage in Pregnancy**—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in fetuses given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cecilor<sup>®</sup> (cefactor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers**—Small amounts of Cecilor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Cecilor is administered to a nursing woman.

**Usage in Children**—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

**Adverse Reactions** Adverse effects considered related to therapy with Cecilor are uncommon and are listed below.

**Gastrointestinal symptoms** occur in about 2.5 percent of patients and include diarrhea (1 in 70). Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

**Hypersensitivity reactions** have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia, and frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain**—Transitory abnormalities in clinical laboratory test results have been reported. Although the were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic**—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic**—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal**—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

**Note:** Cecilor<sup>®</sup> (cefactor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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## Oklahoma State Medical Association

AUGUST 1985

VOL. 78, No. 8

#### EDITORIAL

Phoney Drugs and Foolish Decisions ..... 299  
MARK R. JOHNSON, MD

President's Page ..... 300  
ELVIN M. AMEN, MD

#### SCIENTIFIC

Bilaterally Enlarged Adrenal Glands — An  
Important Clue to Disseminated Histoplasmosis ..... 301  
LESLEY M.F. CHOOI, MD; DOUGLAS P. FINE, MD;  
HAROLD G. MUCHMORE, MD; MERLE D. CARTER, MD;  
DON A. WILSON, MD; REBECCA G. TISDAL, MD

Epidemiology of Nontuberculous Mycobacteria  
in Oklahoma ..... 304  
P. PAUL G. OMONDI, PhD; NABIH R. ASAL, PhD;  
HAROLD G. MUCHMORE, MD; D.J. FLOURNOY, PhD

#### COMMENTARY

Nightmare Afternoon: The Star School Disaster ..... 313  
JOHN E. POARCH, MD

#### NEWS ..... 321

PMTTC plans "Alliances in Rural Health" . . . Former medical  
school dean starts work in Houston . . . Tulsa hosting confer-  
ence on adolescent medicine and ambulatory pediatric care  
. . . Heart association accepting grant applications . . .  
"Perry A." sparkles in Chicago . . . The JOURNAL needs your  
help . . . State delegates stay busy at AMA meeting . . .  
Study suggests "defensive medicine" at work . . . Norman  
MD wins office with wildlife federation . . . AMA warns  
against tanning booths . . . Donor cards still scarce

#### DEPARTMENTS

State Department of Health ..... 319	Miscellaneous Adv. ... 11A
Deaths ..... 331	Index to Advertisers ..... 30A
In Memoriam ..... 331	Instructions for Authors ..... 30A
Reaction Time ..... 332	The Last Word ..... 32A
Book Reviews ..... 333	

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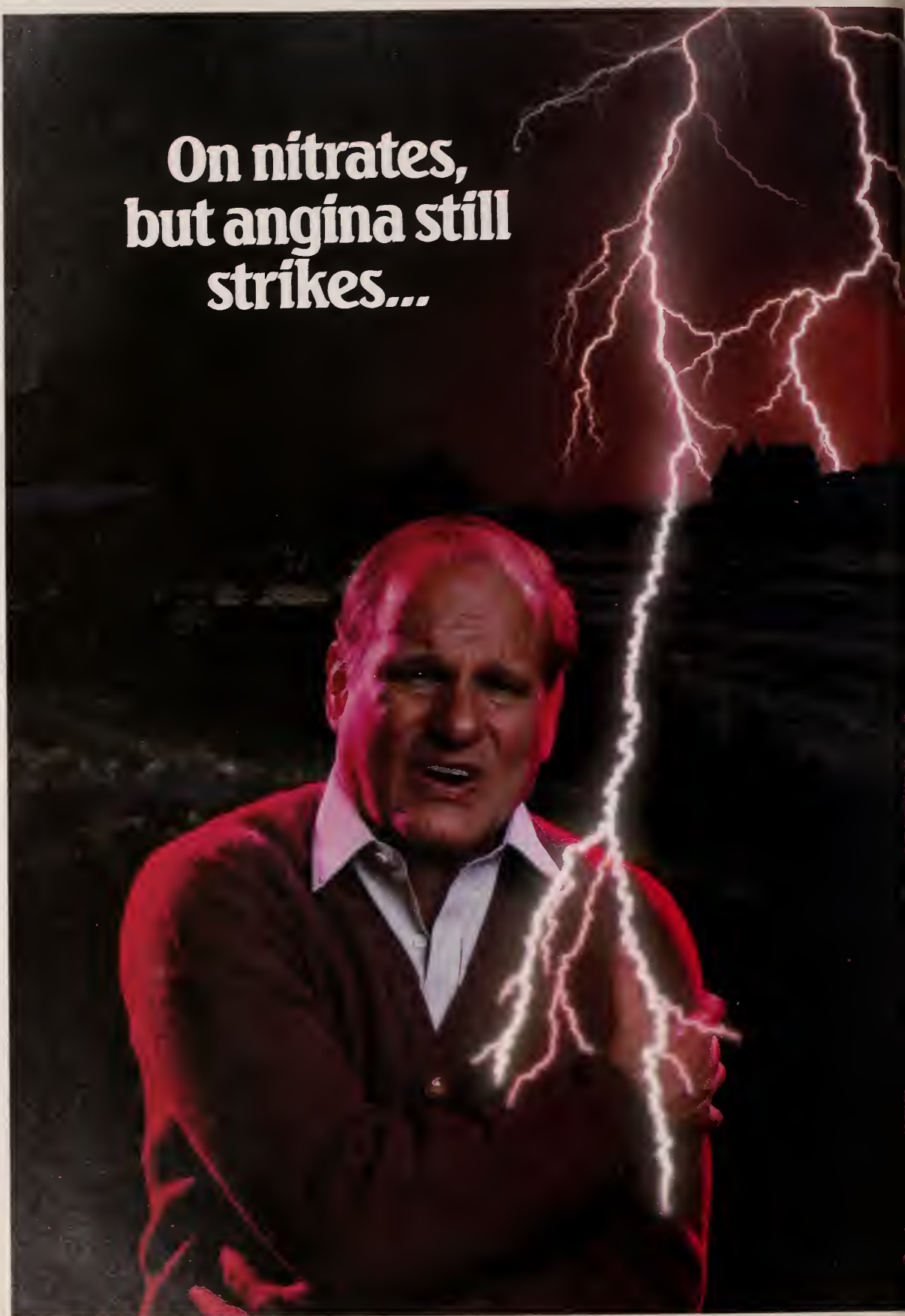
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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (HSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. **Pregnancy Category C:** There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984

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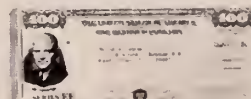
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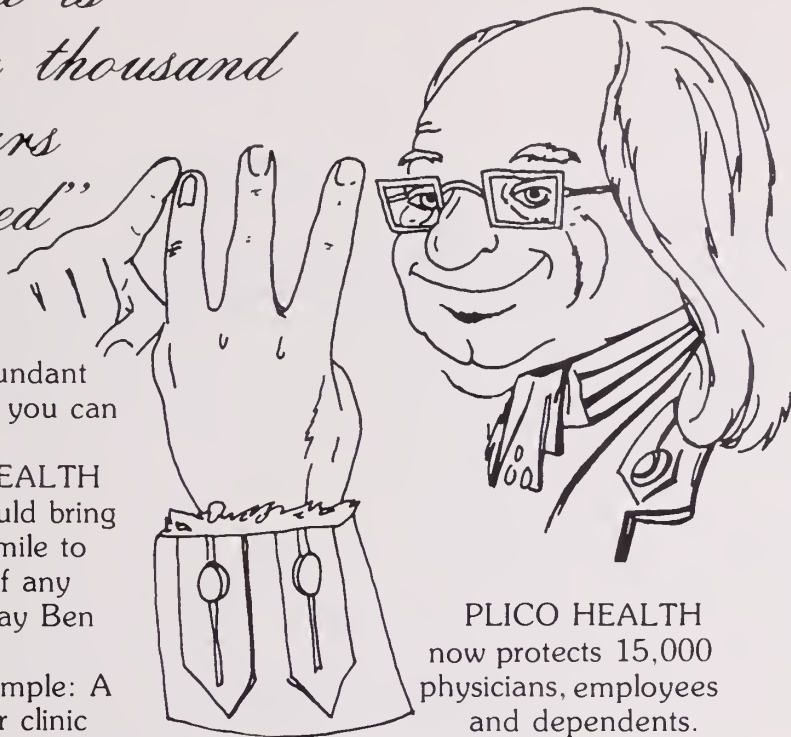
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**OKLAHOMA MEDICAL POLITICAL ACTION COMMITTEE**

Post Office Box 54520  
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## Phony Drugs and Foolish Decisions

It is no secret that for years retail markets in this country have been invaded by a plague of counterfeit products, complete with phony labels, logos and manufacturers' tags. In some cases it is estimated that the sale of counterfeit items has exceeded the sale of the genuine articles. Labels, containers and logos have been matched so perfectly that a whole new security business has emerged based on the merchant's need to be able to recognize the honest product.

It should be no surprise that this criminal and potentially lethal activity also involves the drug industry. Counterfeit automobile parts have been identified as the cause of accidents in which drivers and passengers have lost their lives. Can anyone doubt that counterfeit drugs have been responsible for the deaths of uncounted numbers of patients whose lives depended on the relatively delicate balances maintained by prescribed medications? Can anyone doubt that clinical research results have been seriously flawed because of the inadvertent use of counterfeit drugs or reagents? Can anyone doubt the urgent need for an effective surveillance system in this highly vulnerable area?

The improbability of discovery, the inestimable amounts of money involved, the ease of acquisition and substitution and the relative lack of security in the warehousing and distribution of drugs and medications of all kinds combine to make drug counterfeiting an almost irresistible crime; a seductive path to

riches. Items of preference in street drug markets, expensive and frequently prescribed medications — particularly the generics with less sophisticated physical characteristics — probably hold the greatest appeal among counterfeiters.

Even the most cursory assessment of the potentials in this field of criminal activity evokes a chilling response. Axiomatically every crime that *can* be committed *is* being committed.

So what is being done about it? Is there even one study underway designed to estimate the magnitude of the problem? Is any federal or state regulatory or law enforcement agency studying the problem? Is anyone proposing solutions to the problem? Frankly I do not know answers to any of these questions, but someone should. And the answers should be shared with the American people *now*.

I guess it's possible that those who make decisions about such problems believe it is more important to determine whether a particular antihistamine is effective, possibly effective or not effective in controlling a runny nose. Or whether a combination of aspirin, acetaminophen and caffeine is more effective in relieving a headache than any of the single ingredients alone.

If they do believe this nonsense, I'll just have to accept their decision and deal with the counterfeit drug problem as an individual physician.

It wouldn't be the first time I've disagreed with a bureaucratic decision.

— MRJ



**T**he Annual Meeting of the American Medical Association is over. As usual, your Delegation from Oklahoma has worked in an outstanding manner, and has set an example that is respected by all other delegations. At no time were we without total representation during discussions or at voting time.

We are proud of our Dr "Perry A." Lambird. He



and our staff presented a fine candidate and a fine campaign which resulted in victory for Dr Lambird on the first ballot. Even the hotel staff were impressed, and hoping for his victory.

We are hoping for a great year. Let's all work diligently toward restoring the confidence of the people in our profession.

Sincerely,

*Elvin M. Amen, M.D.*

# Bilaterally Enlarged Adrenal Glands — An Important Clue to Disseminated Histoplasmosis

LESLEY M.F. CHOOI, MD; DOUGLAS P. FINE, MD; HAROLD G. MUCHMORE, MD;  
MERLE D. CARTER, MD; DON A. WILSON, MD; REBECCA G. TISDAL, MD

**Adrenal insufficiency is a well-known but infrequent complication of histoplasmosis. In the case presented here, a CT scan of the patient's abdomen showed bilaterally enlarged adrenal glands; this finding led to the identification of disseminated histoplasmosis. Bilateral enlargement of the adrenal glands is a valuable clue that justifies careful investigation of histoplasmosis as a diagnostic possibility.**

Infections with *Histoplasma capsulatum* present with manifestations ranging from self-limited, asymptomatic infection to chronic pulmonary disease to a disseminated and potentially fatal illness. Disseminated disease is often difficult to confirm even when suspected, and months or years may elapse between onset of symptoms and definitive diagnosis and therapy. In the case discussed here the diagnosis of histoplasmosis was pursued because of the finding of adrenal enlargement in a computed tomography (CT) scan of the abdomen.

A 61-year-old white man presented in March 1983, with a four-month history of weakness, lethargy, intermittent fever, and chronic cough. A physical examination at that time revealed nothing abnormal. Laboratory studies showed SGOT of 41 mU/ml (normal 0-21), SGPT of 65 mU/ml (normal up to 19), LDH of 277 mU/ml (normal 40-110), alkaline phosphatase of 63 mU/ml (normal 30-80), total bilirubin

of 0.7 mg/dl, creatinine of 2.3 mg/dl, leukocyte count of 7,000 per cu mm with a normal differential, hemoglobin of 15.4 gm and hematocrit of 43%. A morning cortisol level and the rest of the chemistry profile, including the electrolytes, were normal. Serology was positive for hepatitis A IgM antibody but was negative for hepatitis B antigen and antibodies. No specific therapy was administered at that time. Because the symptoms persisted, a CT scan of the abdomen and pelvis was obtained in April 1983 (Fig). This test showed a normal liver with mild splenomegaly and bilaterally enlarged adrenals, the right measuring 2.5 x 4.8 cm and the left 1.7 x 1.7 cm. Because of this latter finding, a complement fixation test for histoplasmosis was done, and was reactive (1:16 to yeast phase antigen). Subsequent titers (performed at a different laboratory) were reactive at dilutions of 1:4 and 1:2 only.

The patient continued to be symptomatic, and because of the persistently elevated liver enzymes, liver biopsies were performed in August and December 1983. These showed inflammatory cell infiltrates involving the portal tracts and parenchymal lobules, with small histiolympocytic granulomas present on the second biopsy specimen. However, fungal cultures were negative. During hospitalization for the second liver biopsy, hepatosplenomegaly was noted.

About 19 months after the onset of his symptoms and 11 months after the CT scan showing the enlarged adrenal glands, the patient was first seen at the University of Oklahoma Health Sciences Center.

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His symptoms included fever to 103°F, with chills, anorexia, and mild confusion. He had no documented weight loss. He was a depressed, moderately obese white man who appeared older than his stated age. Vital signs were normal. No cardiac murmurs were detected. The only significant findings were a liver edge palpated approximately 2 cm below the right costal margin and a spleen palpated at 4 cm to 5 cm below the left costal margin.

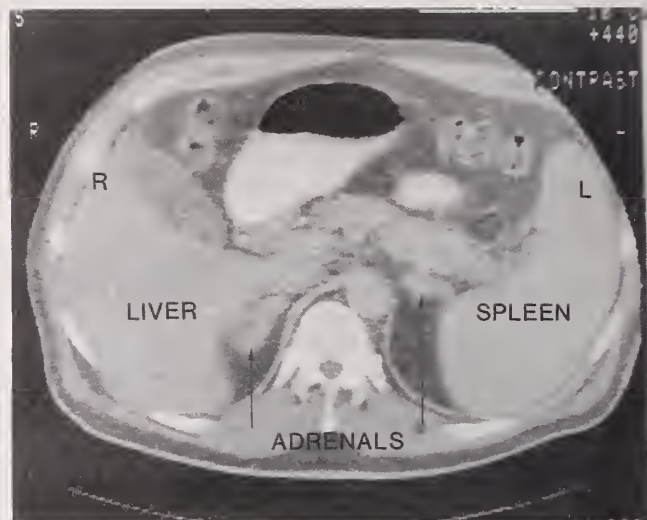
Laboratory studies now showed SGOT of 30 IU/L (normal 5-35), SGPT of 17 IU/L (normal 15-35), LDH of 191 IU/L (normal 90-190), alkaline phosphatase of 54 IU/L (normal 50-136), leukocyte count of 5,300 with 18% bands, 32% segs, 26% lymphs, 14% monocytes, 7% eosinophils, hemoglobin of 12.7 gm, and hematocrit of 38%. The previous finding of enlarged adrenal glands was confirmed on a repeat CT scan, and histoplasmosis continued as the major diagnostic consideration. Bone marrow biopsy and aspiration were obtained for fungus and routine cultures. The biopsy showed a noncaseating granuloma and the culture of the aspirate yielded *H capsulatum* after 10 days incubation at 25°C. The patient was then placed on oral ketoconazole 600 mg daily.

Three weeks later, he experienced acute onset of right leg pain and progressive pallor of that extremity. A right femoral arterial embolus was surgically removed. The histopathology of the clot revealed numerous small budding yeast cells, and the culture again grew *H capsulatum*. A two-dimensional echocardiogram was negative for any valvular vegetations, and ultrasonography of the abdominal aorta

## **In the chronic stage of disseminated histoplasmosis adrenal involvement is frequent.**

did not show an aneurysm. During this hospitalization a 48-hour cosyntropin (Cortrosyn<sup>®</sup>) stimulation test showed no response, indicating adrenal insufficiency.

The patient was treated with 2.5 gm amphotericin B with excellent clinical and hematological response. Replacement adrenal hormonal supplementation was required.



CT scan of abdomen. Right adrenal gland is enlarged. Enlargement of left adrenal gland was apparent on lower sections. Spleen is also enlarged.

## **Discussion**

Early in the course of his illness this patient was found to have bilaterally enlarged adrenals, and because of this finding disseminated histoplasmosis was suspected. In disseminated disease *H capsulatum* is found in the cytoplasm of reticuloendothelial cells.<sup>1,2</sup> The buffy coat and the bone marrow are readily accessible sources of these cells for culture, and marrow culture was successful in recovering the fungus in this patient.

*H capsulatum* has a predilection for the adrenal glands, and in the chronic stage of disseminated histoplasmosis adrenal involvement is frequent.<sup>1</sup> The resulting inflammation and necrosis may lead to adrenal insufficiency. At the time of the first CT scan, our patient had normal plasma cortisol, but adrenal insufficiency developed insidiously during the next 11 months. However, prior to the availability of a CT scan of the abdomen, adrenal enlargement was not readily detectable. Of 102 patients reported in six autopsy series,<sup>1-6</sup> 79% showed bilateral adrenal involvement. Wilson et al<sup>7</sup> recently reported seven patients with disseminated histoplasmosis, all of whom showed bilateral adrenal enlargement on CT scan. A significant feature noted was that these enlarged glands usually maintained their shape. In one of the patients in their series, CT guidance of an aspiration needle was used to obtain material for culture of the fungus. This procedure would have been utilized in our patient if the bone marrow cultures had failed to grow.

Our patient subsequently developed an infected embolus to the right femoral artery, most probably

arising from a cardiac valvular lesion. This event has been previously described as a complication of disseminated histoplasmosis.<sup>3</sup>

Conclusion

CT scan appears to be a valuable tool to assist in earlier diagnosis of disseminated histoplasmosis. The finding of bilaterally enlarged adrenals in the appropriate clinical setting should suggest this disease entity. □

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Coming next month . . .

Among the manuscripts being considered for publication next month are a report on outpatient cisplatin chemotherapy and a study of return service scholarship applications in Oklahoma. Also being reviewed is a brief commentary offering a medical student's view of the rapidly changing medical profession. Already scheduled is the text of Dr Edward N. Brandt's address to medical students attending the OSMA's Annual Meeting in May.



# Epidemiology of Nontuberculous Mycobacteria in Oklahoma

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HAROLD G. MUCHMORE, MD;<sup>2</sup> D. J. FLOURNOY, PhD<sup>2</sup>

**Acid-fast bacilli isolates at the Oklahoma State Department of Health were analyzed for the period covering 1978 to 1983 in order to ascertain the descriptive epidemiology of nontuberculous mycobacteria (NTM). NTM isolates in Oklahoma have increased dramatically, and since 1982 they have surpassed *Mycobacterium tuberculosis* as the most prevalent isolates in the state.**

The clinical significance of the nontuberculous mycobacteria (NTM), once thought to be harmless, is now well established. Their pathogenic potentials have been magnified further by recent publications that have identified them as a major source of complications in victims of acquired immune deficiency syndrome (AIDS).<sup>1,2</sup>

Much of NTM research has centered around their epidemiology. A more recent technique of studying the descriptive epidemiology of these organisms is by analyzing records on culture isolates obtained from the laboratory.<sup>3-6</sup> Although culture isolates do not necessarily represent disease, they serve as useful indicators of trends and distribution of these organisms in the population.

The purpose of this study, therefore, was to analyze the data on the acid-fast bacilli (AFB) isolates centrally collected at the Oklahoma State Department of Health (OSDH) for the period covering

1978 to 1983, in order to determine NTM's secular trends. NTM's isolate distributions by month, race, age, and county of patient residence were also analyzed.

## Methodology

The data were abstracted from AFB report forms maintained for each specimen cultured by the Laboratory Division of the OSDH. The forms are filed alphabetically by the name of the patient and by the year the specimen was processed. The OSDH is obligated to maintain these culture reports for at least five years, and so the period for which the reports were available dated back to 1978. The data covered a five-and-a-half year period from January 1978 until June 1983. The records abstracted totaled 1,679, with 37 variables per record.

In addition, data were obtained from a laboratory logbook that gives a monthly account of the total

Table 1.—Cultures Processed at OSDH 1978-1983

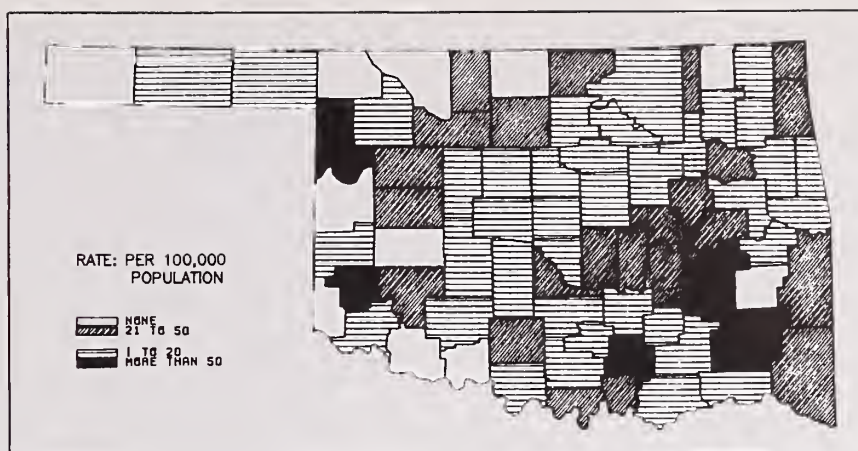
Year	Total Specimens	Positive Cultures	TB	NTM
1978	8806	1248	756	492
1979	11198	1592	904	688
1980	10954	1401	772	629
1981	10563	1449	806	643
1982	10984	1517	729	788
1983	9709	1447	656	791
Total	62214	8654	4623 (53%)	4031 (47%)

1. From the College of Public Health, University of Oklahoma Health Sciences Center.

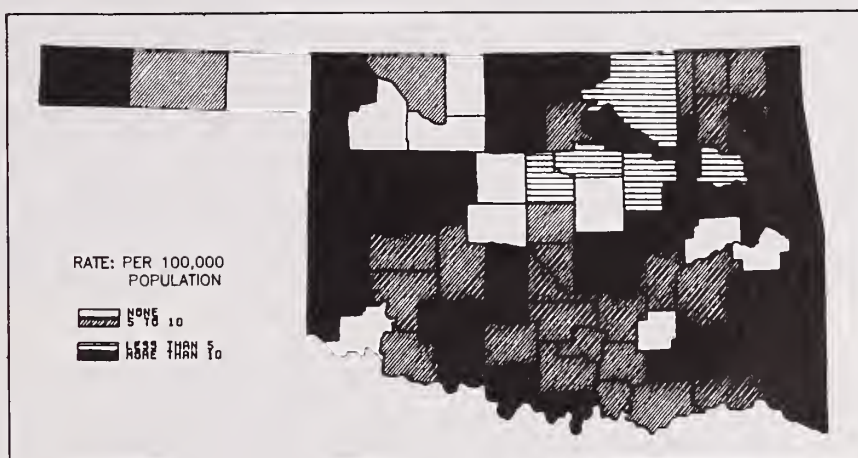
2. From the College of Medicine, University of Oklahoma Health Sciences Center.

Reprint requests to: D.J. Flournoy, PhD, VA Medical Center (113), 921 NE 13th Street, Oklahoma City, OK 73104.

**Fig 1.** — Distribution Rates of *M intracellulare-avium* Complex Culture Isolates by Oklahoma Counties for Period 1978-83



**Fig 2.** — Distribution Rates of Other NTM Culture Isolates by Oklahoma Counties for Period 1978-83



number of specimens processed. Further, the logbook identifies positive AFB isolates by species. Information in the logbook was available from January 1978 to December 1983.

The abstracted information was then entered into the computer. With the exception of variables on patient names, names of their attending physicians, and addresses, which were entered in alphanumeric characters, all other variables were entered in numeric codes. Duplicate records were omitted.

The calculation of isolation rates reported in Fig-

ures 1 and 2 as rates per 100,000 population were obtained by dividing the organism frequency in the counties by the counties' respective population as reported by the Census Bureau. These records were also the source of information on degree of county urbanization presented in Table 3.<sup>7</sup>

## Results

Table 1 represents a summary of breakdown of the 62,214 culture results at OSDH. Of the 8,654 positive AFB indicated, 4,623 (53%) isolates were due to *M tuberculosis* and 4,031 (47%) isolates were due to the nontuberculous mycobacteria (NTM). Counts represented on this table include repeat cultures.

Table 2 represents frequencies of the species of NTM isolated at OSDH from 1978 to 1983. It shows that *M intracellulare-avium* complex was the most commonly isolated NTM organism (42%) followed by *M gordonae* (33%) and *M fortuitum* (11%).

When positive isolates are subdivided into isolates of *M tuberculosis* and NTM as in Figure 3, isolates of *M tuberculosis* are shown as having undergone a decline since 1978. NTM isolates, on the other hand, show a dramatic increase in the six-year period of the study. In 1982 NTM supplanted *M tuberculosis*

**Table 2.**—Frequency of NTM Species Isolated at OSDH 1978-1983

Organism	Freq	Percent
<i>M intracellulare-avium</i> complex	623	42
<i>M gordonae</i>	489	33
<i>M fortuitum</i>	168	11
<i>M kansasii</i>	114	8
<i>M terrae</i>	39	3
<i>M scrofulaceum</i>	32	2
<i>M flavescens</i>	13	.5
<i>M phlei</i>	5	.3
<i>M szulgai</i>	3	.2



Table 3.—Percent Urbanization and NTM Frequency Rates for Eighteen Counties Reporting All Three NTM Groups

County	Organism Rates/100,000			
	Percent Urbanized	<i>M intracellulare-avium</i> Cplx	<i>M kansasii</i>	Other NTM
Blaine	31	7.43	7.43	14.87
Bryan	39	6.55	3.27	6.55
Carter	71	16.05	4.59	9.17
Cleveland	85	10.51	1.50	6.00
Comanche	86	9.78	2.67	17.78
Creek	42	13.55	3.39	3.38
Ellis	0	71.47	17.86	35.73
Garfield	81	35.02	4.78	23.88
Grady	48	7.60	2.53	10.12
Kay	77	28.08	4.01	12.03
Love	0	26.78	13.38	40.17
Muskogee	60	13.44	7.47	10.45
Oklahoma	98	15.82	4.92	9.14
Payne	73	14.41	3.20	4.81
Rogers	31	2.15	8.61	6.46
Texas	48	16.92	5.64	5.64
Tulsa	94	17.00	6.59	16.57
Washington	79	20.78	6.24	6.23
Spearman correlation coefficient		-0.53	-0.77	-0.51

as the most predominant AFB isolate. NTM counts increased from 492 in 1978 to 791 in 1983. *M tuberculosis* counts, on the other hand, declined from 756 in 1978 to 656 in 1983.

The NTM isolates are further broken down into isolates of *M intracellulare-avium* complex, *M kansasii*, and "other NTM" in Figure 4. The predominant species is *M intracellulare-avium* complex which, with the exception of a dip in 1980, rose to a peak in 1983. *M kansasii*, considered the most pathogenic of the NTM species, had a much lower incidence. Its peak was in 1982. The rest of the NTM, lumped together as "other NTM," exhibit a fairly steady frequency.

To test for seasonal variation, culture isolate distributions were examined by month of reporting over the six-year period.

The distribution of monthly frequency means for *M tuberculosis*, *M kansasii*, *M intracellulare-avium*

complex, and other NTM are represented in Figures 5, 6, 7, and 8 respectively. No clear patterns of high and low distributions are evident, but it is interesting to note that *M tuberculosis* and *M kansasii* both exhibit low frequency means in the warmer months of July through September.

Figure 1 represents rate distributions of *M intracellulare-avium* complex (the most frequent NTM organism) isolates by Oklahoma counties. No organisms are indicated in eleven counties, eight of which are in the western half of the state. Clustering of rates in excess of 21/100,000 is not evident, although three counties with such rates are in the southeastern region of the state and two are in the west.

The distribution of the *M kansasii* rates by county is not illustrated due to the organism's small frequencies.

The distribution rates for the other NTM are illus-

Table 4.—The Observed and Expected Frequencies of *M intracellulare-avium* complex, *M kansasii* and Other NTM Among Whites, Blacks and Indians

	Whites		Blacks		Indians		X <sup>2</sup>	p	N
	Obs	Exp	Obs	Exp	Obs	Exp			
<i>M intracellulare-avium</i> complex	267	244	10	21	18	18	7.92	>.02	295
<i>M kansasii</i>	46	41	2	4	1	3	2.94	>.20	50
Other NTM	179	194	19	16	32	14	7.50	>.05	234

Fig 3. — Frequency of *M tuberculosis* and NTM Isolates for Period 1978-83

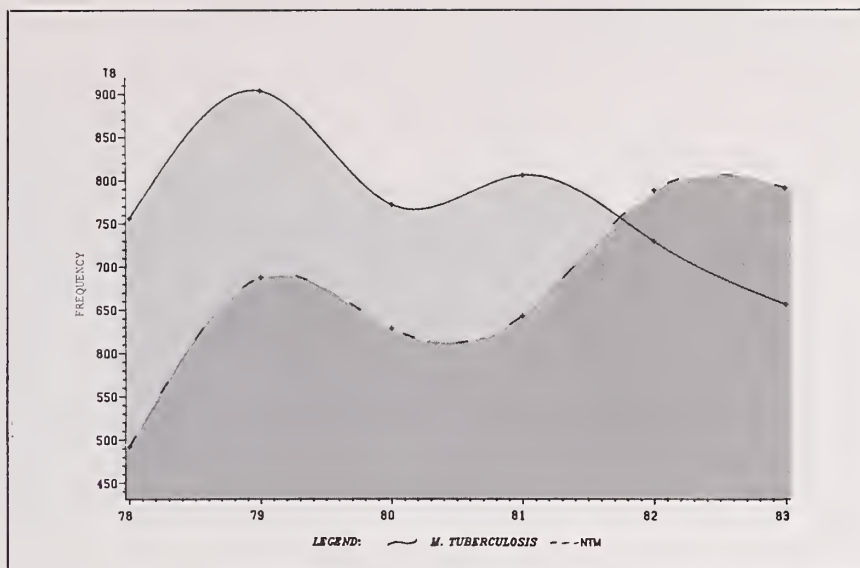
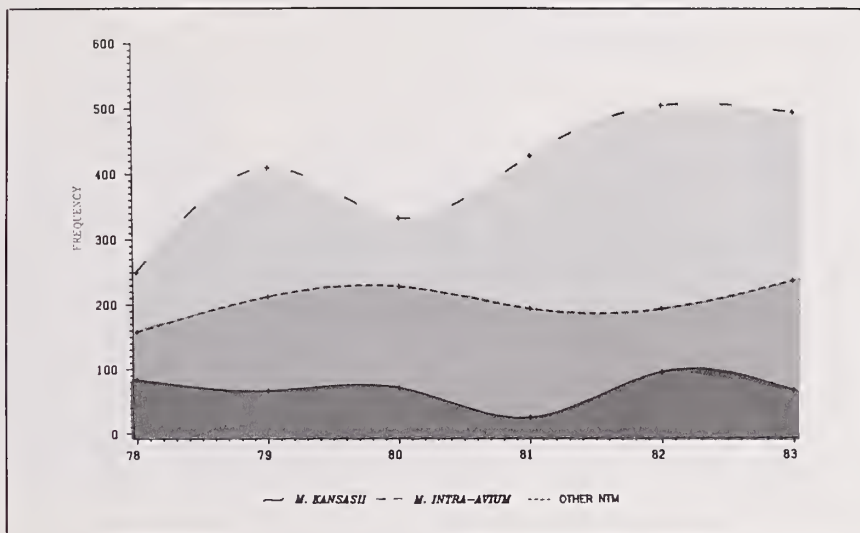


Fig 4. — Frequency of *M kansasii*, *M intracellulare-avium* complex and Other NTM for Period 1978-83



trated in Figure 2. Heaviest rates are in the peripheral counties. Eleven counties show no cases.

The Spearman correlation analysis was performed between the county percent urbanization and frequency rates for the three groups of the organisms for the eighteen counties presented in Table 3.

*M intracellulare-avium* complex gave a correlation coefficient of  $-0.53$ , *M kansasii* gave a correlation coefficient of  $-0.77$ , and the other NTMs' correlation produced a coefficient of  $-0.51$ . The negative coefficients suggest an inverse association between the organisms' isolate rates and the degree of county urbanization, ie, isolates tend to be greater in the more rural counties. The coefficients for both *M kansasii* and the other NTM were significant at the alpha level of 0.10.

Figures 9 to 11 illustrate age-group distribution by sex for *M intracellulare-avium* complex, *M kan-*

*sasii* and the other NTM respectively. In Figures 9 and 11, the age distribution displays a stepwise pattern for both sexes, but in Figure 10 (*M kansasii* isolates) the male distribution does not conform to this pattern; here the peak distribution is in the 50 to 64 year age-group.

Table 4 represents the observed isolate distribution of *M intracellulare-avium* complex, *M kansasii*, and other NTM by race. The expected distributions for each race were generated by multiplying the total number of isolates within the three organism groups with Oklahoma's population proportion for the particular race. This racial proportion is: whites 83%, blacks 7%, and Indians 6%. Among *M intracellulare-avium* complex isolates, whites are overrepresented and the chi-square test indicates the racial distribution to be significantly different at  $p > 0.02$ . Among *M kansasii* isolates, whites are again overrep-



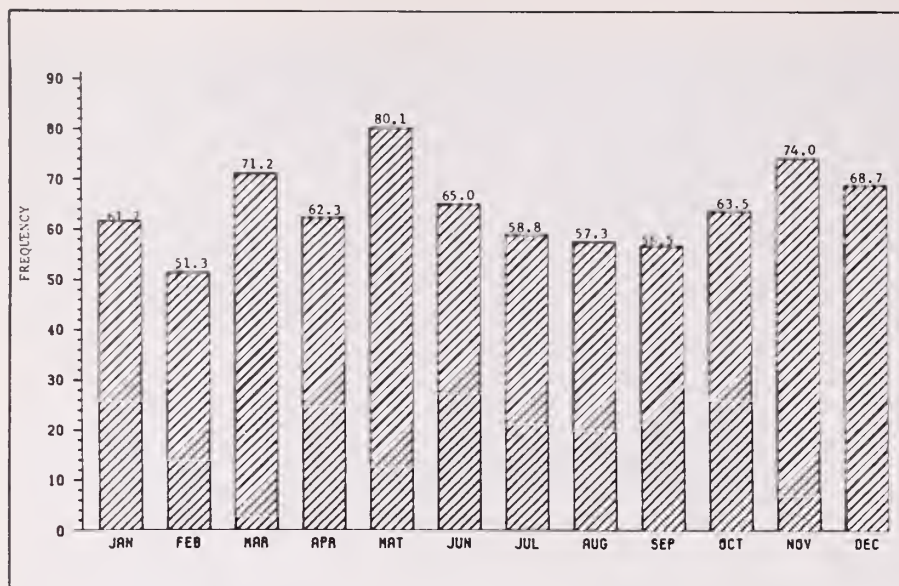


Fig 5. — Mean Distribution of *M tuberculosis* Isolate Cultures by Month for Period 1978 to 1983

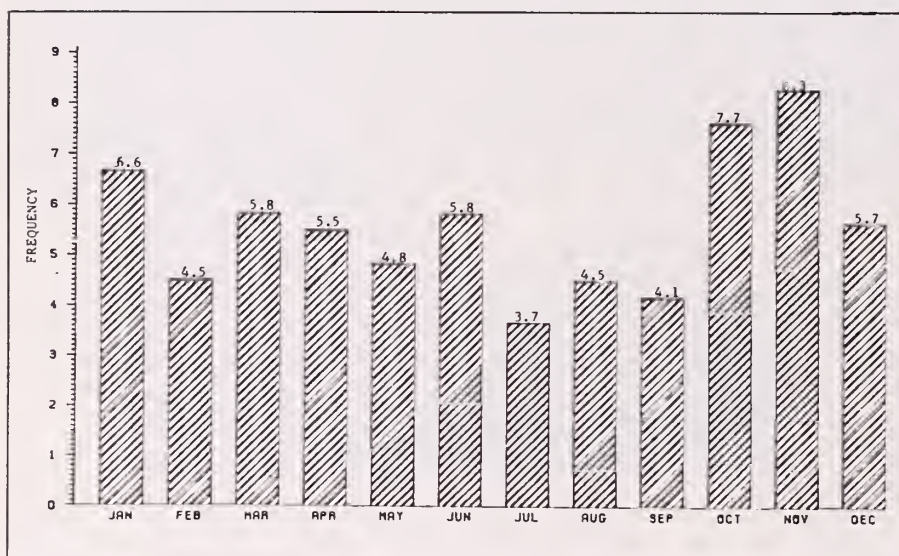


Fig 6. — Distribution Mean of *M kansasii* Isolate Cultures by Month from 1978 to 1983

resented, although significance is not indicated by the chi-square test. Indians are largely overrepresented among the "other NTM" isolates, with the chi-square test indicating the difference in the racial distribution to be significant ( $p > 0.05$ ).

## Discussion

The use of laboratory culture results has emerged as a useful source of data for epidemiological studies of the nontuberculous mycobacteria (NTM). The Laboratory Division of the Oklahoma State Department of Health is the only reference laboratory for acid-fast bacilli (AFB) cultures in the state of Oklahoma. The use of its centrally collected data for descriptive and analytic epidemiology of NTM in Oklahoma establishes the uniqueness of this study.

Over 62,000 cultures were processed at OSDH between 1978 and 1983. The first question that must

be posed about these cultures is: how representative are they of the entire state?

Materials for culture processing are received at OSDH in two different ways. Practicing clinicians may send patient specimens to the state laboratory directly, or through a county health department. Specimens or cultures may also be received from other laboratories, such as those in hospitals, which perform their own culturing but may need the identification services of the OSDH.

Unlike *M tuberculosis*, infection by NTM is not reportable in Oklahoma, but it is believed that most institutions and physicians routinely refer their positive AFB cultures to the state laboratory. For this reason, OSDH's culture records are the most representative available in the state.

The Veterans Administration hospitals of Oklahoma City and Muskogee are the only known excep-

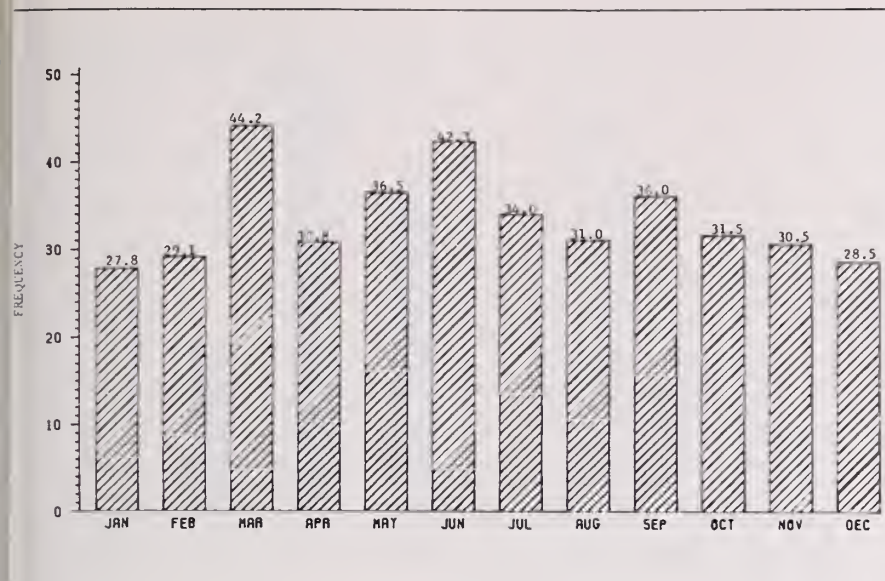


Fig 7. — Mean Distribution of *M intracellulare-avium* Isolate Cultures by Month for Period 1978 to 1983

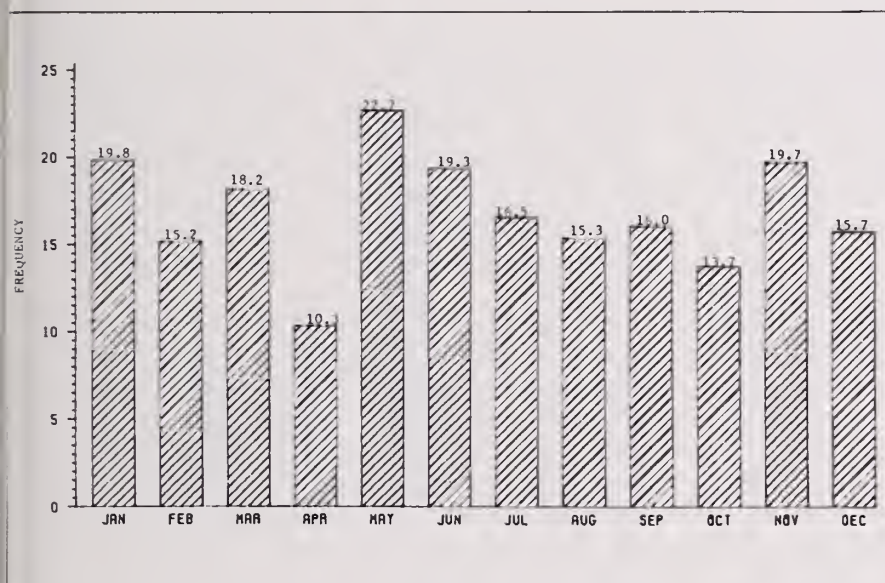


Fig 8. — Mean Distribution of Other NTM Isolate Cultures by Month for Period 1978 to 1983

tions to the practice of referring cultures to OSDH.

Continuing trends in the United States that show an increase in the incidence of NTM and a decrease in that of *M tuberculosis* are well known. The same trends have been noted in the six-year period of this study, but here they are much more dramatic, as illustrated by Figure 3. The increase of NTM, nationally, in the last thirty years has largely been explained by the improved and more thorough laboratory techniques of recent times. This reason seems inadequate to explain the sudden NTM surge seen in this study, because there is nothing to suggest that culturing techniques at OSDH have changed within the period of the study. Also, the number of specimens received yearly shows no corresponding increase (Table 1).

Species of NTM most commonly associated with pulmonary disease are *M kansasii* and *M intracellu-*

*lare-avium* complex. Table 2 and Figure 4 show that *M intracellulare-avium* complex has consistently been the most predominant isolate during the period of the study. In a study by Fogan<sup>3</sup> it was estimated that over 50% of individuals excreting *M kansasii* had apparent disease caused by this organism as opposed to only 27% for *M intracellulare-avium* complex. In spite of *M kansasii*'s greater pathogenicity, it seems that *M intracellulare-avium* complex constitutes the most common NTM pulmonary pathogen in Oklahoma, outnumbering *M kansasii* six to one. A previous study of laboratory cultures spanning a twenty-one-year period at the Veterans Medical Center<sup>4</sup> revealed that *M kansasii* was the most predominant isolate. Reviewing these cultures from 1978 onwards, however, it is found that isolates of *M intracellulare-avium* complex predominate.

One of the major epidemiological concerns involv-



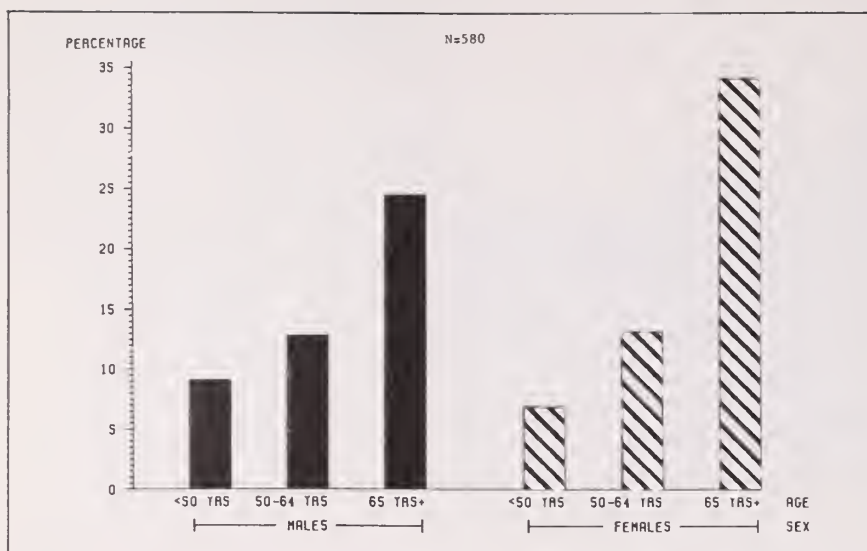


Fig 9. — Percent Distribution of Isolates of *M intracellulare-avium* Complex by Age Group and Sex

ing infectious diseases is seasonality. This aspect has not been adequately investigated for NTM. Omondi et al<sup>4</sup> reported a tendency to higher frequencies of isolates in the warmer months of the year. In our study, Figures 5 and 6 show that the opposite seems to be the case. Here, both *M tuberculosis* and *M kansasii* show lower means in the warmer months of July through September.

Although the reasons for this apparent seasonality are not clear, it is not surprising that a similarity of monthly distribution is exhibited by *M tuberculosis* and *M kansasii* and not by other NTM organisms. *M kansasii* exhibits several other characteristics which indicate its similarity to *M tuberculosis*; these include its pathogenicity, its susceptibility to drugs, and its antigenic properties.

Knowledge of the geographic distribution of NTM is crucial to the understanding of their etiology. It has been hypothesized that pulmonary infections by *M intracellulare-avium* complex and *M kansasii* could be facilitated by water. By a method of aerosolization called "bubble-burst, jet-drop mechanism," Parker et al<sup>8</sup> have demonstrated that air bubbles, originating from natural waters, burst at the surface, ejecting jet droplets to a height of several centimeters into the air. Upon drying, these droplets release the infective microorganisms. Prevalence of these organisms in aquatic environments has been demonstrated<sup>9-12</sup>

The eastern half of Oklahoma has a higher average annual rainfall than the western half, and it also has more surface area of lakes and ponds than the west. It was hypothesized that a clustering of NTM rates in the eastern counties would be demonstrated to support the hypothesis that NTM pulmonary infection may be related to regions with larger areas of surface water.

As can be seen from Figures 1 and 2, no definite clustering is demonstrated. Although the figures do not support the hypothesis, they do not necessarily disprove it. The American society is a fairly mobile one; in fact, the Census Bureau estimates that only 53.6% of Americans lived in the same house both in 1975 and in 1980. For this reason, accurate information on geographical distribution is usually difficult to obtain.

Several papers have noted the urban-rural difference in the prevalence of disease caused by *M intracellulare-avium* complex and *M kansasii*. An attempt was made to verify this claim in our study. In spite of the report by Ahn et al<sup>13</sup> that cases of the former tend to occur in rural areas and the latter in urban areas, our study found a negative correlation between isolates of both organisms and the degree of county urbanization. However, these correlations were not statistically significant.

Two possible explanations may help to account for this disparity of results. First, our study reports only on the individuals with isolates of the organisms and not on patients with confirmed disease. The manifestation of disease may be dependent on some host factors that may be related to their residential backgrounds, ie, urban or rural. Secondly, in spite of the fact that the Census Bureau has its own criteria for determining the extent of urbanization in the counties, some would argue that most of Oklahoma is altogether rural. It would be interesting to compare Oklahoma with some of the larger industrial states.

The overrepresentation of whites among the *M intracellulare-avium* isolates is consistent with prior observations that NTM infections tend to occur in whites more than in other races in the United States.

There is a distinctive difference in the distributions of age and sex between *M intracellulare-avium*

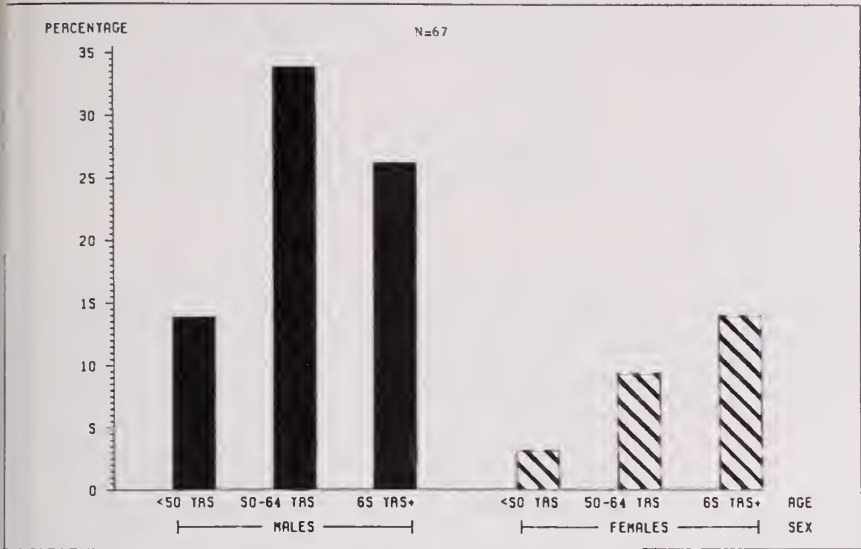


Fig 10. — Percent Distribution of Isolates of *M. kansasii* by Age Group and Sex

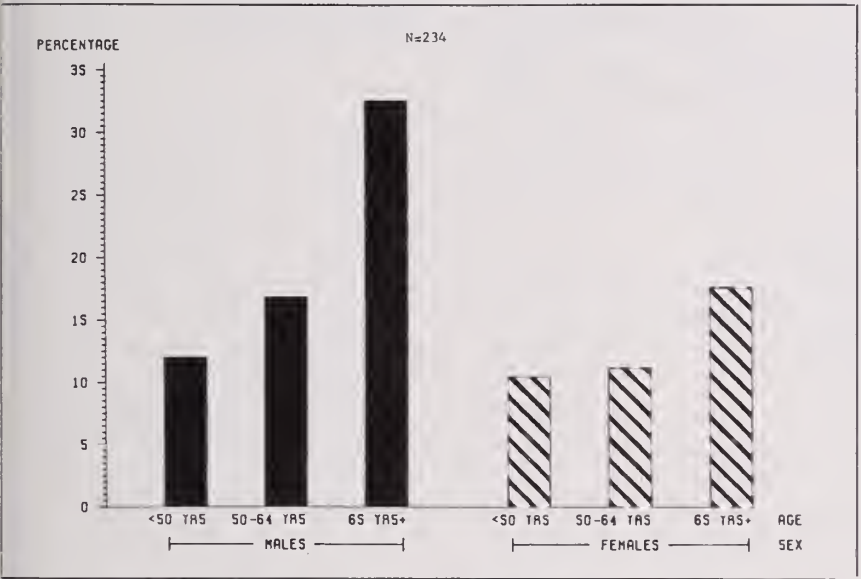


Fig 11. — Percent Distribution of Isolates of Other NTM by Age Group and Sex

complex and *M. kansasii*. As seen in Figures 9 and 10, isolates of the former organism occur mostly in individuals of age 65 and over, and those of the latter occur mostly in the 50-to-64 age group. This finding is consistent with the findings of Ahn et al<sup>13</sup> who reported a higher mean age for the former in Texas.

The sex distributions of the two organisms exhibit an even more striking difference. The overwhelming male predominance in *M. kansasii* is, again, consistent with Ahn et al,<sup>13</sup> who reported a 3:1 sex ratio for the organism in Texas, but the slight female predominance for *M. intracellulare-avium* complex revealed in our study is not consistent with their study.

It is difficult to explain the sex difference in the isolates of *M. kansasii*, but this is further evidence of the similarities between this organism and *M. tuber-*

*culosis*. Nationally, tuberculosis is more prevalent in men, and according to statistics compiled by the OSDH, the number of tuberculous men in Oklahoma is at least twice the number of tuberculous women.<sup>14</sup>

### Conclusion

In summary, for the period 1978 to 1983, the NTM isolates in Oklahoma have increased dramatically, and since 1982 NTM isolates have surpassed *M. tuberculosis* as the most predominant isolates in the state. *M. intracellulare-avium* complex constitutes the most predominant NTM isolate in Oklahoma, and it is on the increase. Because of the overwhelming frequency of its isolates, *M. intracellulare-avium* complex is most probably the predominant cause of NTM pulmonary disease in Oklahoma, even though *M. kansasii*



is acknowledged as more pathogenic. In spite of many claims that there is an urban-rural difference between *M kansasii* and *M intracellulare-avium* complex, our study was unable to demonstrate such a difference.

Racial distributions of the isolates show that whites tend to be overrepresented, relative to their population in the state. Indians are also overrepresented, while blacks tend to be underrepresented.

*M kansasii* isolates in Oklahoma have an overwhelming preponderance in men, whereas *M intracellulare-avium* complex isolates in the state are preponderant in women. □

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Where the telescope ends, the microscope begins.  
Which of the two has the grander view?

—Victor Hugo  
*Les Misérables*

*I was there to help myself  
because it scared me to think of it  
happening to my three children.*

## Nightmare Afternoon: The Star School Disaster

JOHN E. POARCH, MD

The following communication was a presentation at Professorial Rounds in the Child Psychiatry Division of the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center on May 30, 1984. The idea was to share the intense fear empathically experienced during the afternoon of the Star School disaster, in order to increase the tolerance for such discomfort. Perhaps, too, it will prepare other professionals in the mental health field to behave similarly during future disasters, and help them realize that through not avoiding discomfort, we make ourselves more effective helpers.

You saw the title on the activity sheet: "A Nightmare Afternoon." Another title might have been "A Task No One Wants."

I hope this all going to fit into a package that will get my message across. First I am going to talk about opposing views of craziness and then I am going to talk about terror. Initially, obvious terror and then insidious terror. Subsequently, I will review the disaster afternoon.

Now to our views of craziness and of sanity. The first example involves Povl Toussieng. One psychiatrist saw Povl as psychotic because he cried when he was saying goodbye to a child that was going to be withdrawn prematurely from therapy. Some of us would view that as beautiful, and some of us would view it as psychotic. That is a dramatic distinction.

For another example, imagine a man being taken to the emergency room. He dies there of a heart attack. In the meantime his wife has been notified, and when she arrives she is told that her husband is dead. She then has a fit. She is screaming, writhing . . . Now, most likely, someone will administer some kind of sedative to calm her.

We feel like we are doing her a great service by giving her relief. Yet in doing so, we are treating her as if there is something wrong with her reaction, as though it is inappropriate. It is, in reality, the most natural reaction on earth — remember that. It is not unlikely that we will be working with that same woman three or four years hence, trying to make the connection between her symptoms and her loss — because we covered up the natural reaction in the emergency room.

I will extend that concept a little bit. Most of us

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***Really being real,  
in my opinion, is telling somebody  
exactly the way it is . . .***

were reared by parents who were relatively afraid of people and afraid of children. That is, they were afraid of feelings and impulses. Feelings and impulses made them uncomfortable. So, if we were to be good children (who shows more feelings and impulses than children?), we had to try to hide our feelings and be careful about our impulses. The more we tried not to exist, so as not to scare them, or make them uncomfortable, the better children we were. "Now, that's a good child. No trouble."

You see, if we tell it the way it is, and *express* it emotionally the way it is, we make people uncomfortable. They have feelings about that.

Really being real, in my opinion, is telling somebody exactly the way it is, even though you are afraid it might make them have a heart attack, even though you are afraid it might make them never have anything to do with you again, or that it might make them go crazy, or make them kill you, or themselves. But, being *real* is being able to do that. Most people can't. You run into very few.

If we are to help the people who come to see us, we have to be able to help them tolerate more discomfort. Like us, most of the people who come to see us find that letting themselves feel more alive makes them miserable. If they lose control of their feelings, they feel like monsters (when the feeling is anger). If they get very excited, they feel sure they are going to be ruined.

The compulsive man, while he is getting better, is going to be telling you how miserable you are making him. He's the patient who says, "You're no help," when you say, "That's the help," as he goes out the door grumbling. That's when you are being helpful, not when you are making them feel better. If they happen to feel better because of understanding, that's great; but just to make them "feel better" is not being helpful, in my opinion.

So, really helping people involves being able to help them tolerate and experience more intense discomfort or terror. The terror you feel when you are betraying your heritage and your family is telling you that you are a bad person because you are making them uncomfortable. Aside from that, they know you are going to grow up and be able to leave them and

be able to do without them; why would you need them? They have to trust that you will be with them because you want to. *That's scary.*

### **Terror**

That brings us to *terror*. More obvious terrors would be someone holding a gun to your head or a train two feet away from your car door. These happened to me. The train was going 55 miles an hour. I spent the next few days in the hospital. Or grabbing a paranoid man who is drunk and has a gun in his hand — that was terrifying. (He started crying and dropped the gun.)

Another example would be walking into the admitting office at the Veterans Administration Hospital at 2:00 in the morning to confront a patient who is menacing three people with a long butcher's knife. I still have the knife; I don't have the gun. The knife was saved and presented to me when I finished my residency. Those are obvious terrors.

I am going to talk to you, now, about terrors that are not so obvious. If we brought a patient in here for me to interview today, and the patient were depressed or sad, we might all feel that way within a few minutes. If the patient were furious, we might feel furious within a few minutes. If the patient were confused, we might all feel confused. That is just simple elementary empathy, right? Yes! Also, if the patient were very paranoid, we might also feel paranoid very soon. But, would we know we were paranoid because it came from the patient? If the patient were psychotically paranoid, we wouldn't. Otherwise, he wasn't psychotic. Does that make sense?

Part of psychosis is not being able to differentiate other from self, so when you pick up feelings from the psychotic patient, you don't know, maybe until midnight, or two or three days later, what has been going on. Indeed, if you do then. I am talking about insidious terror. Paranoia would be rather obvious. You could bring in an undifferentiated psychotic patient who didn't have hallucinations or delusions. He would communicate the psychotic emotional state while, on the surface, it could seem that he was making some kind of sense; but then you might go home

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## ***Detachment works to keep the fear from interfering with your functioning.***

and be very uncomfortable that evening and drink too much, or have a fight, or lose control with your child and not know why, or fuss with your wife when there was no apparent reason. That is insidious terror. We might wake up in the middle of the night, maybe for two or three nights, but that's the occupation we are in.

It helps if you understand. It helps if you know; otherwise, a lot of things happen to you and you don't know why.

When I was going through my training, I spent most of my time trying to be cool, and trying to make it look like I was well put together. That was only because I was afraid I wasn't. Of course, there is not much reason to be in this business unless you do have that fear, in my opinion.

### **The Nightmare**

Now, imagine the insidious terror, the worst one I can think of — that of spending most of the day not knowing whether your child is alive or dead. January 19, 1982 — the longer the day went on, the more the people who hadn't heard were afraid that it was going to be *their* child who turned out to be dead.

I was on my way back to my office after lunch, thinking about my one o'clock patient, when over the radio came the news of the disaster. It scared me. It quickly went through my mind that that could have been Deer Creek school, and those could be my children. That idea terrified me. I felt so helpless.

I could probably have got away with avoiding the compulsion to go out there to try to do something to relieve my helplessness if it hadn't also been announced on the radio that they were having all the parents gather at the Community Center in Midwest City. It occurred to me that there must be something, surely something, I could do, considering my skills and education. The idea filled me with anxiety.

I saw my one o'clock patient, but I couldn't concentrate, and I knew that for me to stay and try to see people all afternoon would be a total waste of their time and mine. It would also be a waste of their money. When that session was finished I told my secretary to call and cancel the remainder of the afternoon's appointments. I told my waiting patients,

a married couple, what I was doing, and I headed toward Midwest City. I planned to ask directions to the Community Center when I arrived inside the city limits.

Having been a consultant at many different agencies and in many different situations, including schools, I knew that it is one thing to walk in where you are asked, and it is quite another when you walk in where you are NOT asked. You are usually treated like a second left shoe, particularly if you are a psychiatrist, because people are afraid of you in the first place. You generally symbolize just what they want to hide, even from themselves.

I had a lot of detachment serving me well that day. I will explain that further later. We will be getting more and more into where I am going to be empathically communicating, regardless of what my words say, intense discomfort.

With great fear and trepidation, I went on toward Midwest City. When I arrived near the hospital there was a policeman directing traffic, a helicopter landing, and several ambulances waiting to unload behind the hospital. I asked the policeman for directions, and he pointed out the Community Center which was across the street. Of course, I had imagined all sorts of things ahead of time. The most appealing was that there would already be a disaster team in action and somebody from Mental Health already present and trained to deal with these things. I don't think that the police major in charge of the center knows to this day that I wasn't that person, or anyone that was prearranged.

I was almost numb with detachment as I parked. I went to the nearest policeman, who pointed out a lieutenant, and the lieutenant told me to go see the major.

I found the major and a captain in an office adjacent to the anteroom. They were very busy making plans. There were very few people in the center as yet. Contrary to my expectations, I was not avoided. The people there immediately made me a part of the team. This was an emotional event, not a discussion. Almost instantly we became a decision-making body.

Our first task was to decide how we were going to bring the parents and children together. All the



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***"If any of you have Valium . . .  
and you are tempted to take one or  
give it to someone else, don't do it."***

school buses were coming to the center's parking lot, bringing the uninjured children from the school. They were on the way during our discussion. We determined not to have the parents gather around the buses as they came, for fear of confusion and chaos. We decided to have the children stay with their teachers, as they were coming in class groups, and be brought into an open area inside the Community Center. The parents would then pick up the children and the teachers could account for them.

After that, I want you to know that most of the time I wasn't busy. Most of the time I was standing around feeling awkward and out of place, but, when I was busy, I WAS BUSY.

When one of the lieutenants came out to make announcements to the crowd about an injured child, I had a feeling that there was a tendency to try to hide information or be very careful and cautious about how information was distributed. I approached him and said, "Listen, we are going to have chaos here if there is a feeling that you are trying to hide information. When you get on that microphone, you talk loud and clear and say it just like it is; we will write the names of the injured children and what hospital they are in back here on the bulletin board. We could have terrible trouble with the amount of tension and fear in here. If we don't handle it well, we might have utter chaos." Because I came across firmly, he allowed as how I probably knew what I was talking about, and he did as I asked.

Then I took the microphone. By this time we had a large crowd. It had seemed like moments and it seemed like hours had passed at the same time. I wasn't sure what I was going to say. It is amazing how, when your adrenalin is flowing, that is, when you are scared to death, if you have had experiences like those I described earlier that lead you to do what I was doing, everything comes to you. Detachment works to keep the fear from interfering with your functioning.

I said, "Ladies and gentlemen, we are all very frightened. It would be ridiculous if we weren't. We can't have relief and there is no one that can give it to us. If any of you have Valium or any other tranquilizers in your purse or pocket, and you are tempted

to take one or to give it to someone else, *don't do it.*" I proceeded to tell them why. The reaction that we were all having was all VERY natural and to cover it up or delay meant it would come out in symptoms later, when we wouldn't know what was causing them. That would just add to and reinforce the fear.

That was the most significant point. There are lots of things from that afternoon that I don't remember. (There is a paper about the Chowchilla<sup>1</sup> kidnapping that explains part of this phenomenon.)

As the children were brought in and the parents picked them up, there were, of course, always a few children left from each class. I went about the task of assigning those children to volunteers. With my skills and many years of experience working with children, I was better able to communicate with the children than most of the adults there. I did not speak condescendingly (most people don't speak to children as if they are people). Although some of the children couldn't answer many of our questions, we could usually get information that would enable us to locate a parent or guardian. Naturally you ask where their parents work and their phone numbers, but small children, particularly when they are scared, can't always come up with that information. I might sit down and talk with one for a while, and then an association might trigger a memory. It is important not to increase the children's fear by demanding information from them. There were probably twelve to fifteen instances of that nature over a period of two to two and one-half hours.

(It seemed that whenever someone showed a lot of emotion, someone else thought I ought to help.) Once, early on, a woman came up to me and said, "You are needed over here." (No one was afraid to ask for a psychiatrist under those circumstances.) I was led to a woman who was sobbing intensely. (I was saying to myself, "What do you want of me; what can I do?") I asked what had happened. The woman who called me said, "Her sister is the teacher that was killed." Until that moment, I didn't know a teacher had died. I leaned against the wall beside the weeping woman. She continued to cry, and of course, the woman who had come for me was very uncomfortable because she wanted the other woman's

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***It is not really  
as though you tell people.  
They can feel it.***

pain relieved. I said, "Really, the most and the least we can do is share her pain, tolerate it without trying to fix or relieve it."

The weeping woman calmed somewhat, and so did the woman who had come to get me. We waited awhile longer, sharing, and when her sobbing subsided somewhat, we moved over to some chairs and sat down. I stayed with her a few more minutes and then moved on.

(Breaking voice) If at any time I do cry, it will be a nice thing, because as you can tell, I haven't let go of this event. I probably won't for a long time. That is also explained in that paper I mentioned.

Toward the end of the afternoon, or somewhere around 5:00 or 5:30, I was going repeatedly to the information desk that Civil Defense had set up in the lobby. I asked how many were dead and what their names were. Our numbers were dwindling greatly, and as that happened I had more and more contact with the people remaining. Of course, the fear and desperation were mounting more and more rapidly.

I don't remember the names of any of the police officers or any of the other people that were there. I think that's because everyone that I was talking to was *me*. I also doubt that anybody there could tell you my name. I think that is a very significant part of the disaster phenomenon.

There was one person from a mental health center who stayed a short while, but I didn't see him again after I met him. There were two ministers who came and they were fantastic. The three of us made a hell of a team. Many things occurred without verbal communication. Everyone was there to help. Someone would do something, and it would fit in with what you were doing, and so on.

Finally, when we did get the names of the dead children, there was a slight panic about who was to tell the parents. Since I had had that task before and wasn't afraid of it, I somehow felt that I was going to do it. By this time, many of the decisions were being deferred to me. I had become an authority figure.

I asked if there was a more secluded place available, and I think of the place that was chosen as

chapel-like although, as I think back, it really wasn't. It was about the size of this classroom, with several long tables and folding chairs. It was just off the lobby.

Suddenly, before I knew it, the first couple was brought around and we were inside the room and I was telling them —

It is not really like you tell someone. A neighbor of mine lost her child in an accident. Her son had gone with my second son on a mountain climbing trip the previous summer. Three of us arrived simultaneously to tell her that her son had been killed in a car wreck in New Mexico. We walked up to her door at 9:00 in the evening. She opened the door, and said, "What do you want?? What are you doing here? What's the . . . is it Rex?" I said, "Yes."

It is not really as though you tell people. They can feel it.

Once, when I was an intern, I talked with two patients who had bronchiogenic carcinoma. I shared the fact that they were likely going to die. It was more like I was aiding them in admitting what they already knew.

By that time in the afternoon, it was as though the parents already knew. It was odd. People's reactions make you realize how some people in Germany could walk without resistance into a pit to be killed, while others could escape the country, start thinking of ways to make a bomb to destroy Hitler, and work day and night as hard as they could to bring that to reality. Some people were passively accepting, as though they were victims, which describes the first couple.

Next, there was a man who came alone. He said he had come to pick up his wife's child. It was as though he was not in any way related to the boy he was to pick up. I don't know what the reality was, but I know when I told him he just seemed to feel very awkward. It didn't arouse much emotion in him except the terror from the idea of death. (After I told someone, I would stay a few minutes and let them talk to me and respond. Then I would leave them with one of the ministers and move on to somebody else.) At the time I thought I would have liked to have one room in which to tell each family, but as I thought about it later, I think maybe it helped every-



***"I wish there were some [answers],  
and I wish it would help  
if there were."***

one to be experiencing the event with other people. We got many different reactions, so what one person couldn't express, or get in touch with, he could see someone else express. ("That's how I REALLY feel.")

The third family had some relatives with them. The man responded by pounding on the table until he was exhausted. He would rest, then resume pounding. He looked up with burning eyes, as though he could kill, and yelled, "Somebody is going to pay!! I'm gonna get some answers!! You gonna give me some answers??"

Looking him straight in the eyes, our faces just two feet apart, I answered, "No, I wish there were some, and I also wish it would help if there were." It is amazing how words can come at those moments to fill that need.

Later that evening I was to see this man and his wife on television being interviewed in their home. He was still very angry, but his eyes weren't the same. I wondered what he would have been like if we had treated him as if he were dangerous and had given him medication or, worse, gotten a straitjacket.

The whole afternoon was a very, very ambivalent involvement. This is evident from the fact that although I was functioning relatively well, I was there, yet not there. I was detached, emotionally removed. I couldn't believe I was doing what I was doing. It seemed unreal. All the way home it was almost as if I had to pinch myself: "I really did that!" I was proud of it on one hand, but it was though it was too unreal to tell other people.

It was if I was crazy. I could not understand the heroes I saw in movies when I was young — like Audie Murphy when he was running against German machine gun nests. "Did you do that to be a hero?" "No, I did it because I was compelled to do it. I sure wouldn't do it for any other reason. I wouldn't do it for the glory, that's for sure." I went out there because I was compelled to do it. I was there to help myself because it scared me to think of it happening to my three children.

I talked a little about the experience with my family, and several other people in the next few days. I didn't sleep well for several days, but then I got it sealed up and it stayed sealed.

It did occur to me that I should talk to my colleagues about the event, that it would be very worthwhile for all of us to share such an experience, but once it was sealed up it didn't occur to me again for nearly two years. I was working on a case of child abuse, and that case scared me to death. I wrote it up, and I talked by phone to Povl Toussieng about presenting it, and in the same breath I mentioned sharing the Star School afternoon with you. During the next two hours after that phone conversation, I wished I hadn't mentioned it. All the anxiety and fear started coming back while I was trying to see patients. It has been with me ever since.

The last three nights I haven't slept very well because of all the experiences of that day and all the terrors of my life, like the train wreck, the man with the gun, the knife, doing my brother's eulogy after he shot himself, all of them.

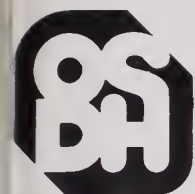
As you can imagine, I haven't been easy to live with since I said I'd do this. Because I no longer need the detachment that served me so well that day, it has not been there. You can read more about some of the phenomena that I am trying to describe. Lenore Terr puts her own labels to them in her paper, "Chowchilla Revisited." It's in the December 1983 issue of the *American Journal of Psychiatry*.

Another paper you might find useful is "The Buffalo Creek Disaster,"<sup>2</sup> shared with me by Dr Shurley. □

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*John E. Poarch, MD, is an associate clinical professor of psychiatry at the University of Oklahoma Health Sciences Center. He earned his medical degree at the university in 1964 and is certified by the American Board of Psychiatry and Neurology. Dr Poarch is a Fellow of the American Psychiatric Association and a member of the Oklahoma City Clinical Society.*



## Testing for HTLV-III Antibody

Since the first few cases of acquired immunodeficiency syndrome (AIDS) were recognized in June 1981, the Centers for Disease Control (CDC) have received reports of 10,678 cases through June 3, 1985. Mortality has been extremely high, with 5,239 deaths (49%) reported during this time period. Of these cases, 163 were attributed to exposure as a result of transfusion with blood or blood products.

Oklahoma has been fortunate to have a low incidence of AIDS reported within the state. Reports through June 3, 1985, total only 19 cases, with 14 known deaths (74%). One of these cases was linked to possible exposure through blood transfusion.

The etiologic agent in AIDS is the human T-cell lymphotropic virus type III (HTLV-III). On March 2, 1985, the Food and Drug Administration licensed an enzyme-linked immunosorbent assay (ELISA) to detect antibody to HTLV-III. Blood banks operating within Oklahoma are currently testing all units of donated blood for antibody to HTLV-III. It is impor-

tant to emphasize that the new ELISA for HTLV-III is, to date, *only* for blood screening or research purposes. Additional confirmatory testing will be available for those persons found positive on the screening test. There is limited knowledge concerning the prognosis for a patient with a positive HTLV-III test result.

Recognizing the need for alternative screening sites, the Oklahoma State Department of Health will coordinate testing locations within the state. The program will be administered through the Sexually Transmitted Disease Division and will provide counseling prior to testing for individuals seeking this test.

Screening sites have been established in Enid, Lawton, Oklahoma City, and Tulsa. Testing began on June 17, 1985.

Additional information or referral of patients seeking the test may be made by calling local health departments. □

DISEASE	May 1985	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	1	1	7	7
CAMPYLOBACTER INFECTIONS	33	97	56	—
ENCEPHALITIS, INFECTIOUS	2	12	6	9
GIARDIA INFECTIONS	18	82	72	—
GONORRHEA (Use ODH Form 228)	1123	5129	4989	6025
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	18	93	89	—
HEPATITIS A	67	237	177	198
HEPATITIS B	22	83	66	99
HEPATITIS, NON-A-NON-B	7	29	19	—
HEPATITIS UNSPECIFIED	6	34	46	87
MEASLES (RUBEOLA)	0	0	5	144
MENINGITIS, ASEPTIC	9	19	19	29
MENINGITIS, BACTERIAL				
(non-meningococcal, non H. Influenzae)	5	31	25	28
MENINGOCOCCAL INFECTIONS	5	18	18	18
PERTUSSIS	16	65	195	49
RABIES (Animal)	13	51	53	92
ROCKY MOUNTAIN SPOTTED FEVER	14	23	25	35
RUBELLA	1	1	0	1
SALMONELLA INFECTIONS	30	117	119	121
SHIGELLA INFECTIONS	20	69	53	99
SYPHILIS (Use ODH Form 228)	19	86	78	79
TETANUS	0	0	0	0
TUBERCULOSIS	36	111	93	130
TULAREMIA	4	5	4	6
TYPHOID FEVER	0	0	1	1

Diseases of Low Frequency	Total to Date This Year	
ACQUIRED IMMUNE DEFICIENCY SYNDROME	1	
BRUCELLOSIS	3	
LEGIONNAIRES DISEASE	4	
MALARIA	1	
REYE SYNDROME	2	
TOXIC SHOCK SYNDROME	6	
<b>RABIES</b>		
CARTER	Skunk	1
CUSTER	Skunk	2
HUGHES	Skunk	1
KAY	Skunk	1
KIOWA	Skunk	1
McCURTAIN	Skunk	1
MUSKOGEE	Skunk	1
ROGERS	Skunk	1
TILLMAN	Cat	1
TILLMAN	Skunk	2
WASHITA	Skunk	1



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## PMTC urges big turnout for "Alliances in Rural Health"

Oklahoma's Physician Manpower Training Commission (PMTC) has played a significant role in planning the program for the upcoming Mid-America Conference on Rural Health.

"Alliances in Rural Health" is the theme for the conference, to be held September 5-7 at the Arlington Resort Hotel and Spa in Hot Springs, Arkansas. It is being sponsored by the National Rural Health Care Association, Regions VI and VII of the US Public Health Service, and Midwest Rural Health Associates in cooperation with the University of Missouri-Kansas City School of Medicine, Office of Continuing Education.

Oklahoma, with its vast rural areas, is deeply



involved in the problems of rural health care, and the PMTC is hoping to see a large Oklahoma contingent at the conference. The program is designed to promote better communication and cooperation among physicians, administrators, nurses, and all health professionals and institutions involved in rural health care. Representatives from all of these sectors are urged to attend.

Included in the large group (plenary) sessions are such topics as public policy issues in rural health, viability of rural hospitals, and rural health care financing. Simultaneous workshops will focus on clinical and administrative skills. Clinical presentations will include farm stress, office dermatology, and perinatal health. Administrative programs will discuss rural prepayment systems, marketing, and maximizing Medicare revenues.

Conference registration fees are \$125 for physicians and \$75 for other health professionals. The fee includes course materials, refreshments, and the luncheon and Lake Hamilton cruise on Friday, September 6.

For further information or to receive a registration brochure, contact the Office of Continuing Medical Education, University of Missouri-Kansas City, 2220 Holmes, Kansas City, Missouri 64108, (816) 276-1339, Attention: Christy Snow, Coordinator. Also providing information is the NRHCA office, (816) 421-3075.

## Former dean of OU medical school assumes post at Houston hospital

Charles B. McCall, MD, who announced his resignation as dean of the University of Oklahoma College of Medicine in April, begins his new duties at Houston's M.D. Anderson Hospital and Tumor Institute this month.

As vice president for patient affairs he will be responsible for several programs that provide emotional and educational support for all patients. He will also help administer M.D. Anderson's large training program for medical residents and fellows in the subspecialties of cancer patient management.

Dr McCall became dean of OU's College of Medicine in February 1982. Prior to that he was chief of staff of Oklahoma City's Veterans Administration Medical Center.

A native of Memphis, Tenn, he earned his undergraduate and medical degrees from Vanderbilt University. □



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## Tulsa meeting to focus on adolescent and pediatric care

"Adolescent Medicine and Ambulatory Pediatric Advances: 1985," a regional meeting scheduled in Tulsa next month, is expected to attract physicians in several specialties.

To be held Friday and Saturday, September 27 and 28, at the Doubletree Hotel Complex, the meeting is being sponsored by the Oklahoma Chapter of the American Academy of Pediatrics, the Midwest Region of the Society for Adolescent Medicine, Region VII of the Ambulatory Pediatric Association, and the University of Oklahoma Tulsa Medical College.

Says Kimball Austin Miller, MD, program coordinator and director of the adolescent health care section at the college, "We are looking forward to

having a large regional meeting here in Tulsa for pediatricians, internists, family practitioners, and adolescent medicine specialists."

On the program as speakers are Drs Robert Haggerty, Donald Greydanus, Heinz Eichenwald, Donald Gross, Robert Endres, Katherine Smith, Charles Ginsburg, Wallace Clyde, and Donald Wilson.

This continuing education activity will meet the criteria for 11 educational credit hours.

For more information contact Dr Miller, Section of Adolescent Health Care, University of Oklahoma Tulsa Medical College, 2815 South Sheridan Road, Tulsa, Oklahoma 74129, (918) 838-4838. ☐

## Heart association now accepting applications for 1986-87 awards

The Oklahoma Affiliate of the American Heart Association has announced that applications for its 1986-1987 research awards are now being accepted.

Awards will be made in three categories: (1) research grants-in-aid, which provide project support up to \$25,000 including overhead; (2) fellowships, which offer stipend support; and (3) Young Investigator awards, providing two-year support at

\$25,000 a year.

The deadline for submission of applications is November 1, 1985. Affiliate processing and review will be completed by April 15, 1986, and approved awards activated July 1, 1986. Applications are available from the affiliate office, 2915 North Classen, Suite 220, PO Box 11376, Oklahoma City, Oklahoma 73136, (405) 521-9838. ☐

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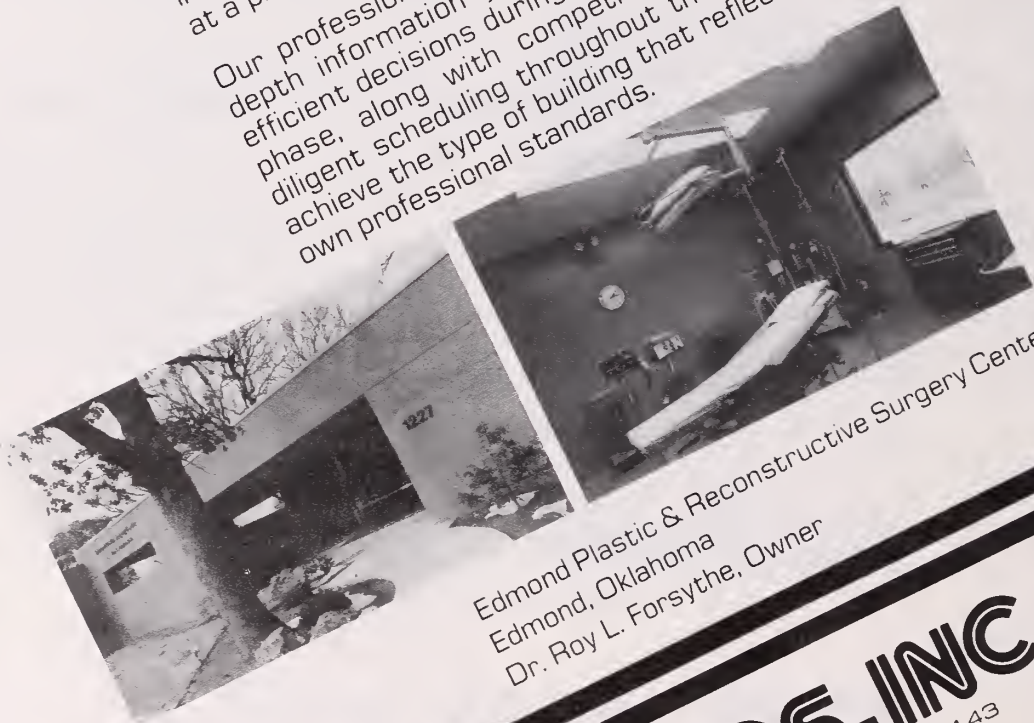
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## 'Perry A' sparkles in Chicago is clear choice for AMA post

As reported in last month's JOURNAL, Perry A. Lambird, MD, Oklahoma City, was victorious in his bid for a seat on the AMA's Council on Member Service. His popular "Perry A" campaign, originated by OSMA Associate Director Robert Baker, made Dr Lambird the "clear, natural" choice of voting delegates at the June meeting in Chicago.

(A) Perry Lambird, the candidate (right), discusses the issues with one of his many supporters.

(B) Tulsans Michael J. Haugh, MD; Norman L. Dunitz, MD; and Floyd F. Miller, MD, speculate on their candidate's chances over a glass of "Perry A" water.

(C) The final tally draws victory smiles from Dr Lambird, his wife, Mona, and daughters Susannah, Allison, and Elizabeth.



A



B

## Planning a meeting? Got a story? The JOURNAL would like to know

Do you have a story about an associate or colleague that might be of interest to other physicians in Oklahoma? A recent award, perhaps, or an unusual hobby? A noteworthy community activity? An upcoming meeting of a special interest group? A seminar? A new project in your organization?

The JOURNAL would like to know about it. As the official publication of the Oklahoma State Medical Association, the JOURNAL provides information for and about the physicians in Oklahoma. You, the reader, can help supply that information.

Send your story to the OSMA JOURNAL, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118. News should be typewritten, double-spaced, to ensure accuracy in spelling, dates, etc.

Please remember, especially when dates are important, that each issue of the JOURNAL closes on the first day of the *preceding* month and reaches readers in the latter half of the month of publication. For example, if you have planned a meeting for mid-November, news of it should appear in the October issue, and must arrive at the JOURNAL office by the first of September. ☐



C



## Oklahoma delegation busy at AMA's June meeting in Chicago



A

(A) Heading up the Oklahoma delegation, OSMA President Elvin M. Amen, MD, Bartlesville (center), studies the delegate handbook with OSMA Deputy Executive Director Rick Ernest (left) and Executive Director David Bickham.

(B) At the microphone, M. Joe Crosthwait, MD, Midwest City, chairman of the Oklahoma delegation, addresses the AMA House of Delegates.

(C) On the floor of the House, Ed L. Calhoun, MD, Beaver, checks his program for the next order of business. Behind him are Dr Crosthwait (partially hidden) and Orange M. Welborn, MD, Ada.

(D) Floyd F. Miller, MD, Tulsa (left), confers with his colleague James B. Eskridge III, MD, Oklahoma City.

(E) Campaigning aside, Perry A. Lambird, MD, Oklahoma City (left), is all business in the House of Delegates. To his left, equally intent, is Victor L. Robards, Jr., MD, Tulsa.



B



C



D

# Retrospective study suggests "defensive medicine" at work

Most routine laboratory tests ordered prior to surgery may not be needed, according to researchers from the University of California, San Francisco. They say 60% of the tests in their study of 2,000 patients "would not have been performed if testing had only been done for recognizable indications."

Furthermore, only 0.22% of those tests revealed abnormalities that might influence perioperative management. "Chart review indicated that these few abnormalities were not acted on nor did they have adverse surgical or anesthetic consequences," say Eric B. Kaplan, MD, and colleagues in the *Journal of the American Medical Association*. (JAMA) They conclude: "In the absence of specific indications, routine preoperative laboratory tests contribute little to patient care and could be eliminated."

Acted upon, their conclusion could exert a major influence on the costs of medical services. The researchers estimate that patient charges would decrease \$147,000 per year at their institution alone.

Comments JAMA Editor George D. Lundberg, MD: "No one quibbles about doing appropriate laboratory testing in the presence of a clinical indication. But in these days of increasing efforts at controlling costs and insisting on appropriate use of resources, the unindicated, routine preoperative laboratory test may well be something that we can do without."

Lundberg points out there are many reasons why physicians order laboratory tests. Among them: screening, peer pressure, personal reassurance, ease of performance with ready availability, hospital policy, medical-legal need, documentation, hospital profit, curiosity, insecurity, habit, and establishment of a baseline.

The study by Kaplan and colleagues was a retroac-

tive evaluation of tests performed on patients admitted to their teaching hospital for elective surgery and therefore was limited to the information that was available on hospital charts. "Such information is not always complete," Lundberg points out.

"We would like to see this retrospective study followed by appropriately designed prospective studies that could define proper practice," he adds. "Meanwhile, the apparent cost/risk/benefit elements that are reported herein should ease the minds of those physicians who may wish to do prospective studies and should militate against a significant professional liability risk for such studies." □

## Norman MD wins VP spot with National Wildlife Federation

George H. Hulsey, MD, a family practitioner in Norman, has been elected vice president, central region, of the National Wildlife Federation, the nation's largest conservation organization.

Dr Hulsey has served on the board of directors of the federation since 1975. Prior to his election as vice president, he served on the board representing Region 8, which includes Louisiana, Oklahoma, and Texas.

Dr Hulsey is a past president and treasurer of the Oklahoma Wildlife Federation, an affiliate of the national organization. His conservation efforts have been recognized with the federation's Conservation Service Award (1971), the American Motors Conservation Award (1974), and the Outdoor Conservationist of the Year Award (1978).

He writes a monthly column, "Wilderness Medicine," for National Wildlife Federation affiliate publications, and teaches seminars on the topic across the country.

Dr Hulsey has served on the boards of several conservation organizations, including the Norman Environmental Control Board, the Oklahoma Forestry Association, and the Oklahoma Coalition for Clean Air. □



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E



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# AMA scientific council warns users of tanning beds, booths

The widespread use of artificial suntanning methods has become a concern to the medical profession, according to an informational report presented to the American Medical Association House of Delegates at its annual meeting in June.

"The high-intensity ultraviolet radiation emitted by these devices has no known beneficial effects to human health and is potentially dangerous," the report says. "Both short-term and long-term exposure may cause immunologic, degenerative, and neoplastic changes in the skin, and retinal damage or cataracts in the eye. While there are procedures that will mitigate somewhat the hazardous effects of ultraviolet radiation, the best protection is to avoid cosmetic tanning altogether," the report adds.

Presented to delegates by the AMA's Council on Scientific Affairs, the report points out that either ultraviolet A or ultraviolet B (representing different wavelengths) sunlamps "produce combinations of ultraviolet wavelengths that are quite different from the mixture of radiation present in natural sunlight."

The desire for bronzed skin has made use of tanning beds and tanning booths popular throughout the United States and in other parts of the world, the report says. The beds allow individuals to recline between rows of sunlamps. The booths allow individu-

als to stand in stalls in which sunlamps are embedded. Both permit whole-body tanning.

"Tanning beds and booths are advertised and sold as being safer than the earlier types of tanning lamps," the report says. "Some even advertise their booths as being so safe that it is not necessary to wear protective goggles while tanning. This statement simply is not true, but such claims can instill a false sense of security in those using the newer tanning devices. Such advertising makes the new tanning devices potentially more dangerous than the older tanning huts because people may be less likely to restrict themselves to short tanning periods."

Calling exposure to ultraviolet A radiation in tanning booths a health hazard, the report nonetheless concedes there are individuals who decide that the cosmetic benefits of tanning outweigh the potential risks, or, more likely, do not understand the risks. "To protect patients who opt for cosmetic tanning in spite of medical advice, the council recommends following 'common sense' rules to prevent possible severe burning and eye damage. Unfortunately, no set of rules will protect against the potential injurious effects to the skin and the immune system," the report concludes. □

# Organ transplants gain support but donor cards still scarce

More than 90% of the population has heard of organ transplantation, but only 19% carry transplant donor cards, according to a national survey.

Conducted by researchers at the Battelle Human Affairs Research Centers in Seattle, the nationally representative survey sampled more than 2,000 respondents. Among findings: 94% had heard of organ transplantation, but only 19% carried cards; 53% said they would donate organs of a relative, while 50% said they would donate their own; and 58% said relatives should not be able to override a person's desire to donate, indicated by a signed donor card.

Significantly, less than 7% of the population supported the concept of presumed, or implied, consent. Under that concept, organ donation compliance is assumed unless otherwise noted by the potential donor. So far no state has adopted such a law.

"Clearly, there are problems with attitude-behavior incongruence, but this incongruence is less severe than it would first appear," note researchers Diane L. Manninen, PhD, and Roger W. Evans, PhD, in the *Journal of the American Medical Association*. "Only about 19% of the population is truly unwilling to donate their organs, while 53% is uncertain. Those

persons who are uncertain may actually represent a pool of willing donors," they add. "This is the group to which educational materials must be targeted."

"The results of the survey also suggest that presumed consent, viewed by some as a possible means of increasing organ availability, would not be very popular among the American public," they emphasize. Less certain is whether or not the "required request" concept might be accepted. Under that system, a potential donor could not be legally declared dead until a request for donation had been made to the next-of-kin.

"An apparent paradox has emerged," the researchers conclude. "On the one hand, people are generally very supportive of organ transplantation efforts as 90% of Americans favor continued development of highly expensive heart, kidney, and other organ transplantation. Yet, on the other hand, people are not yet as enthusiastic about organ donation. . . . The logical goal is to match favorable attitudes concerning organ transplantation with favorable attitudes toward organ donation. Only then will it be possible to conclude that the public has been adequately educated." □



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## DEATHS

### **Hannah B. Karam, MD** 1932 - 1985

Hannah B. Karam, MD, a 1957 graduate of the University of Texas School of Medicine in Galveston, died March 28, 1985. The Enid psychiatrist was born in McAllen, Texas, and moved to Oklahoma City in 1958 for her residency training at University Hospital. Dr Karam was psychiatric consultant for Vance Air Force Base and also practiced at the Garfield Guidance Clinic.

### **L. Chester McHenry, MD** 1901 - 1985

L. Chester McHenry, MD, 1951-52 president of the OSMA, died in Oklahoma City on June 8. A Life Member of the OSMA, Dr McHenry was born in Princeton, Mo, and was graduated from Harvard Medical School in 1925. He completed his postgraduate studies in otorhinolaryngology and established a private practice in Oklahoma City in 1928. During World War II he was chairman of emergency medical services for Civil Defense in Oklahoma City, and in 1946 he helped establish the Oklahoma Medical Foundation. He retired from private practice in the late sixties and was named a University of Oklahoma professor emeritus in 1967.

### **Seigul J. Polk, MD** 1918 - 1985

Oklahoma City internist Seigul J. Polk, MD, a native of Hichita, Okla, and graduate of the St. Louis University School of Medicine, died June 10, 1985. He served in the US Army Medical Corps during World War II and later established a practice in Virginia. In 1961 he moved to Oklahoma City from Lebanon, Va, where he had been chief of medical service at Lebanon General Hospital.

### **Murray M. Cash, MD** 1916 - 1985

OSMA Life Member Murray M. Cash, MD, retired Tulsa pathologist, died in a Tulsa hospital on June 11. Dr Cash, a native of Toronto, Canada, was graduated from the University of Toronto in 1940. He completed postgraduate studies in Tulsa and Chicago and saw active military service in both World War II and the Korean War. Dr Cash established his practice in Tulsa in 1953.

### **Franklin Jesse Nelson, MD** 1896 - 1985

Frank J. Nelson, MD, co-founder of the Glass-Nelson Clinic in Tulsa, died in that city on June 13 at the age of 89. Dr Nelson was born in Caney, Kan, and earned his medical degree at Rush Medical College, Chicago, in 1930. During World War II he was a line officer in the US Navy. An internist, he served on the staff of all of Tulsa's major hospitals before establishing the clinic in 1946. Later he was elected president of the Tulsa County Medical Society. A Life Member of the OSMA and a Fellow of the American College of Physicians, Dr Nelson retired in 1970 after forty years of practice.

## IN MEMORIAM

### 1984

<i>Ingvald John Haugen, MD</i>	<i>September 1</i>
<i>Hugh H. Monroe, MD</i>	<i>September 9</i>
<i>Martin H. Bartlett, MD</i>	<i>September 10</i>
<i>Seth D. Revere, MD</i>	<i>October 6</i>
<i>Oliver H. Patterson, MD</i>	<i>October 13</i>
<i>Emmett H. Lindley, MD</i>	<i>November 8</i>
<i>Clark H. Hall, MD</i>	<i>December 5</i>
<i>Henry G. Bennett, Jr, MD</i>	<i>December 18</i>
<i>Adoniram V. Bowen, MD</i>	<i>December 29</i>

### 1985

<i>Owen L. Hill, MD</i>	<i>January 15</i>
<i>Earl M. Lusk, MD</i>	<i>January 30</i>
<i>Larry L. Lowery, MD</i>	<i>February 12</i>
<i>Harry Wilkins, MD</i>	<i>February 14</i>
<i>William H. Buchan, MD</i>	<i>February 15</i>
<i>Austin H. Bell, MD</i>	<i>February 23</i>
<i>Glen W. McDonald, MD</i>	<i>February 25</i>
<i>E. C. Lindley, MD</i>	<i>March 1</i>
<i>Charles W. Freeman, MD</i>	<i>March 5</i>
<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Hannah B. Karam, MD</i>	<i>March 28</i>
<i>Roy W. Donaghe, MD</i>	<i>May 1</i>
<i>L. Chester McHenry, MD</i>	<i>June 8</i>
<i>Seigul J. Polk, MD</i>	<i>June 10</i>
<i>Murray M. Cash, MD</i>	<i>June 11</i>
<i>Franklin J. Nelson, MD</i>	<i>June 13</i>





## Delegate reports AMA action on manpower problems

*To the Editor:* The two special reports in the JOURNAL (June 1985) on physician manpower encourage me to respond to the membership of the OSMA as to action taken by the AMA House of Delegates in Chicago at the June 1985 annual meeting.

All Oklahoma physicians are strongly aware of the increasing number of physicians and the impact of the Foreign Medical Graduates.

These concerns were voiced in an Oklahoma resolution to the AMA from our Oklahoma House of Delegates and presented at the annual meeting of the AMA in June 1984. I must point out to you, there were serious concerns about our resolution by the AMA legal staff, and our original resolution was modified three times by the AMA Legal Staff & Rules Committee before it was accepted.

The Oklahoma resolution (seriously impaired by amendments) was then referred by a House of Delegates vote and reappeared in a report of the Board of Trustees at the interim meeting in Hawaii (December 1984). This report "S" (I-84) was then accepted in lieu of our Resolution 138 which, in effect, buried it further.

This brings me to the recent June meeting A-85 of the House of Delegates where I was pleasantly surprised to see new "HELP" appear in the form of three new resolutions — all from California — and all voicing Oklahoma's concerns, as well as everyone else's, regarding surplus physicians.

Basically what was again asked of the AMA was (1) to admit or acknowledge the widespread perception of a physician surplus and (2) to act immediately (if not sooner) by the formation of an Ad Hoc Committee or task force to study this problem in depth and also to report back to the House of Delegates in December.

The Reference Committee was impressed with the testimony and brought to the House of Delegates a substitute resolution which was adopted by the House. The adopted resolution contained five resolves and did "recognize the concerns" regarding physician supply (but not admitting to a surplus) and establish a Task Force which will study, evaluate, and report in December 85. It further resolved that the AMA and state medical associations encourage and assist state governments to evaluate their local situations, and resolved further to make available data and ex-

pertise from the AMA and state medical societies (at cost) for these local efforts.

I believe this action by the AMA House of Delegates will be strongly supportive of the recommendations outlined in the special white paper of the OSMA Council on Medical Education (JOURNAL, June 1985).

It is also important to note that the AMA established an Ad Hoc Committee in 1984 to study and report on the issue of Foreign Medical Graduates.

I apologize for the length of this letter but would be pleased if you would consider it as a report from one of your alternate delegates to the AMA from Oklahoma.

William O. Coleman, MD  
Oklahoma City

P.S. I also feel this AMA action helps to answer the question asked by so many of us back home, ie, "What is the AMA doing to help us?"

## Senator replies to Amen letter

*Dear Dr Amen:* Thank you so much for your recent letter regarding my work to repeal the IRS regulation of contemporaneous record-keeping on business vehicles. Your encouragement and kind words about my efforts really mean a lot to me. I will work as hard as I can to serve effectively and responsibly in the US Senate.

Again, thanks for writing. I hope that you will contact me whenever there is legislation of interest to you.

David L. Boren  
United States Senator

## Tulsa doctor offers security tip

*Dear Dr Amen:* I want to compliment you on including information reminding homeowners of steps to be taken to avoid burglary while they are on vacation. It sounds like you may have been a victim yourself at one time.

While all of the steps mentioned are good ones

and are always recommended by the police, you left out one of the most important and that is a good burglar (and fire) alarm system. This protects not only when the family is away from home but when they are at home as well, which is where most of the burglaries occur. Modern, electronic, wireless systems are quickly installed and relatively low in price compared to the safety and peace of mind they engender.

*Leon Horowitz, MD  
Tulsa*

## Special Olympics director says thanks to OSMA

*Dear Dr Eskridge:* It is with sincere gratitude that I write to you and your fellow members of the Oklahoma State Medical Association, on behalf of Oklahoma Special Olympics and the more than 17,000

"special" athletes, thanking you for your generous financial contribution. It is through contributions such as yours that Special Olympians receive training and encouragement to try and try again . . . to scale new heights and to become winners in the game of life.

Dr Eskridge, please convey to everyone with the Oklahoma State Medical Association our gratitude and pride for the interest you share in the welfare of the mentally retarded in our state. To provide these individuals with a quality sports program, to help them grow socially and psychologically as well as physically, and to afford them the opportunity to expand their horizons is our goal. We thank the Medical Association for making it one of theirs.

*Terry Kerr  
Executive Director  
Oklahoma Special Olympics, Inc.*

## BOOK REVIEWS

**Infections in the Abnormal Host.** Edited by Michael H. Grieco. New York: Yorke Medical Books, 1980. Pp 1035, illustrated, \$65.00.

The growing number of patients with a compromised resistance to infection has added a new dimension to nearly all fields of medical practice. An understanding of the abnormal or compromised host requires knowledge of many disciplines, including microbiology, immunology, epidemiology, pharmacology, and therapeutics. Dr Grieco, professor of clinical medicine at Columbia University College of Physicians and Surgeons, and forty-five collaborating authors have provided a comprehensive treatise on the many infectious complications of such patients.

The text is divided into three major sections. The first, which constitutes about one third of the book, reviews normal host defenses and relates these to infectious complications secondary to congenital or acquired abnormalities in the host. Considered are neutrophil function, the complement system, humoral and cellular immunity, and certain other topics.

The second major section is entitled "Infections Associated with the Abnormal Host." It covers infec-

tions by the type of infecting organism and then discusses infections in abnormal hosts such as alcoholics, drug abusers, and patients with uremia, organ transplantation, neoplastic diseases, or infections of specific organ systems. The absence of coverage of the neonate is immediately apparent.

The final section deals with management. It includes a very good discussion of antimicrobial therapy in the compromised host and management of infections due to protozoal and helminthic organisms. There are also sections on immunologic reconstitution and on gamma globulin and vaccine therapy.

Each chapter contains a comprehensive bibliography. The index is well organized, but it does point up redundancy in several sections.

Grieco and his coeditors have provided a very useful book which addresses a timely topic of increasing importance. Its availability as a reference should be made known to all physicians treating the compromised patient.

*Harris D. Riley, Jr., MD  
Oklahoma City*



**Pediatric Surgery.** By Thomas M. Holder and Keith W. Ashcraft. Philadelphia: W.B. Saunders, Co., 1980. Pp 1166, price \$68.00.

In their preface, the editors of this book define their purpose in compiling it: ". . . to provide in a single volume what most students, residents, pediatricians, and surgeons want and need to know about pediatric surgery." They also acknowledge that the book has a scope similar to the original text in this field, *The Surgery of Infancy and Childhood* by Dr Robert Gross, to whom the present volume is dedicated.

*Pediatric Surgery* is a comprehensive, multi-authored textbook with contributions by leaders in American pediatric surgery. The book begins with chapters on general and important topics in this field including the physiology, nutritional support, and anesthesia and monitoring of the surgical patient, and the attending emotional and ethical considerations. This is followed by discussion of disorders of an organ system and general disorders such as "foreign bodies," "burns," and "childhood trauma." The subjects range from disorders as uncommon as conjoined twins to entities as common as hernias. In contrast to certain other texts on the subject, this book covers pediatric urology more completely. Cardiac surgery, in keeping with the practice in most training programs in pediatric surgery, is not included.

In most instances, the general aspects of a disorder, methods of diagnosis, and management are described. Topics not covered as thoroughly have an excellent set of bibliographic references. Little attempt is made to discuss surgical disorders from a physiologic viewpoint, and little laboratory information is included.

The book portrays well the development of and the advances in surgical care of children. It is well organized, the illustrations in general are quite good, and it is recommended for those who deal with children.

Harris D. Riley, Jr., MD  
Oklahoma City

**Clinical Pediatric Dermatology.** By Sidney Hurwitz. Philadelphia: W.B. Saunders Co., 1981. Pp 481, illustrated, \$75.00.

*Clinical Pediatric Dermatology* is an encyclopedic treatise of disorders of the integument in infancy and childhood. It is designed to provide the physician with

information that will allow him to deal effectively with skin problems in the young. It contains nineteen chapters which include a listing of more than 400 different disorders. The initial chapter gives an overview of the diagnosis of dermatologic problems. It includes a definition of terms and discusses certain basic principles such as regional distribution and morphologic patterns of various lesions. Following this, general categories of dermatologic disorders are discussed; among these are cutaneous disorders of the newborn, photosensitivity and photoreactions, disorders of the sebaceous and sweat glands, bacterial and protozoal infections of the skin, and other major categories of skin disease. Most of the discussions are thorough but pertinent and are accompanied by a review of histopathology of the appropriate lesion. Each chapter is accompanied by an extensive list of references.

The book is enhanced by the use of a large number of color photographs.

This is a comprehensive review of pediatric dermatology. It will certainly be of use to all physicians who treat children.

Harris D. Riley, Jr., MD  
Oklahoma City

**Grant's Method of Anatomy by Regions Descriptive and Deductive.** 10th Edition. By John V. Basmajian. Baltimore and London: Williams and Wilkins Company, 1980. \$26.95, 644 pages, 1,007 illustrations.

This, the tenth edition of this well-known text, attests to its use and popularity. As pointed out in the preface by the editor, courses in human anatomy continue to change not only from decade to decade but also from year to year in various medical schools. Clinical emphasis in anatomy has been rediscovered.

This book has always relied heavily on clinical significance as the major justification for the inclusion or exclusion of details. Students receive a perspective on the human body as a logical system of function. Materials have been shifted around in the book and a new radiographic atlas is included. It presents numerous line drawings emphasizing concept in textual material that relies on a rational explanation.

It continues to occupy a useful place.

Harris D. Riley, Jr., MD  
Oklahoma City

**Surface Anatomy. An Instruction Manual.** Second Edition. By John V. Basmajian. Williams and Wilkins, Co., 1983. Illustrated, 68 pages, \$5.95, paper.

This small book is for students and teachers of gross anatomy and physical examination. It defines the principles of surface anatomy — visual and palpable — relating to five body systems. The first edition proved to be popular and the second has been modified further for use by the student. There are new illustrations that enhance the appearance and the presentation of information. This is a useful manual for its intended purpose.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Allergic Diseases of Infancy, Childhood and Adolescence.** Edited by C. Warren Bierman and David S. Perlman. Philadelphia: W.B. Saunders Co., 1980. Pp 837, illustrated, \$49.50.

In the preface the editors state, "Allergy is one of the most common causes of acute and chronic childhood disease. It is the leading cause of school absenteeism for chronic conditions of the respiratory tract and is responsible for a wide range of problems for the child and family." This, then, underlines the need for a comprehensive text dealing with the particular problems of pediatric allergy. In the last few years several volumes dealing with allergy have made their appearance. However, until this one none has been directed specifically to the physician who cares for children.

The editors have drawn together some ninety contributors — pediatricians, immunologists and representatives of other disciplines. The text is divided into twelve major categories comprising sixty-seven chapters. The first three are entitled "Principles of Immunity," "Diseases of Host Defense," and "Etiology and Pathogenetic Considerations in Allergic Diseases." Five of the remaining sections are concerned with management of specific allergic diseases of various systems such as the gastrointestinal, skin, and upper and lower respiratory tracts. There is a section entitled "General Management of Allergic Disease." Another, "Diagnostic and Therapeutic Dilemmas," contains chapters on such common and knotty problems as chronic cough, headache, and surgery in allergic patients. The final section is "Disorders That May Involve Immune Mechanisms."

There is an enormous amount of information here.

For example, food allergy is discussed from a variety of viewpoints including a thorough airing of many of the controversial concepts and techniques. Major endocrine disorders are also comprehensively discussed.

If there is any particular weakness of this book, it is that the focus on the developing individual becomes hazy at points. The great influence of growth is not given its just due, as it influences both health and various disease disorders.

The book is attractively printed and contains good illustrations. Each chapter contains an up-to-date bibliography.

This is the most comprehensive text dealing with allergic disorders of childhood which has appeared, and it is recommended.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Pediatric Procedures.** By Walter T. Hughes and E. Stephen Buescher. Edition 2. Philadelphia: W.B. Saunders, Co., 1980. Pp 367, illustrated, \$24.95.

A second edition of this book, which has found a useful place in childcare circles, is welcomed. During the sixteen-year period since the appearance of the first edition, many new techniques have been developed and applied in pediatric hospital care. Prominent among these has been the evolution of more specialized intensive care units for neonates, infants, and children; improvement of monitoring devices; and the use of new indwelling shunts, prostheses, and lines for diagnostic and therapeutic purposes. This edition discusses in a rational and orderly manner virtually all of the procedures employed in pediatrics, as well as the necessary equipment, method and approach, advantages and disadvantages.

The first two chapters, "Preparation of the Patient" and "Measurements," are excellent. Appropriate emphasis is placed on the comfort of the patient, including the most effective type of restraint. Subsequent sections provide in-depth discussion of procedures such as venipuncture, infusions, bone marrow aspiration, and catheterization at various sites. Separate chapters on procedures relevant to most organ systems — the nervous system, respiratory tract, and genitourinary tract — are included.

A valuable aspect of the book is the inclusion of procedures that may be used less frequently by most pediatricians because there are adequate alterna-



tives. A final chapter is concerned with infection control.

The text is enhanced by some humorous and effective illustrations prepared by the second author, Dr Beuscher, a pediatrician himself.

This book is practical and unique and should be available in the library of all hospitals that care for sick children.

*Harris D. Riley, Jr., MD  
Oklahoma City*

### **Retroental Fibroplasia: A Modern Parable.**

By Wm. A. Silverman. New York: Grune and Stratton, Inc., 1980. Pp 246, price \$23.50.

This small book is by Dr William A. Silverman, a pediatrician who pioneered in neonatology. It was brightened by the author's remarks at the Richard L. Day lectureship at Columbia University in April 1975.

The monograph begins with a historical account of the first recognition of retroental fibroplasia (RLF) and its subsequent delineation. It then provides a brief history of the care of premature and sick infants. The author takes us step by step through the period 1942 to 1952, relating the many theories on the causes of RLF and ending with the implication of oxygen. Silverman then describes the experimental and clinical studies that were carried out to test the oxygen hypothesis.

The RLF story is used as a parable to illustrate many of Dr Silverman's philosophical concepts on the practice of medicine. This includes particularly the implications of inflation in medical manpower and costs. He emphasizes the uncritical acceptance of newer methods of treatment for newborn infants and the failure of physicians to appreciate the widespread implications of their actions. He also dwells on the lack of information provided to the parents of children afflicted by RLF and the consequent misunderstanding of the children themselves. He makes a strong case for closer attention to controlled trials before any new treatment is introduced.

The concluding chapter, "The Future for Studies Involving American Children," contains much food for thought.

The notes on the fourteen chapters are extensive and contain many interesting vignettes. There are also several appendices including an outline of the causes of RLF that have been considered in cooperative studies and the nature of randomized clinical trials. There is an extensive bibliography and the monograph is well indexed.

This is not only a comprehensive account of retroental fibroplasia, now a resurging problem in the United States, but also an excellent overview of the development of neonatology. All concerned with the care of the newly born infant will find this book of interest and its review worthwhile.

*Harris D. Riley, Jr., MD  
Oklahoma City*

Call it what you will,  
discriminating, purposeful reading is good medicine.

—William S. Middleton

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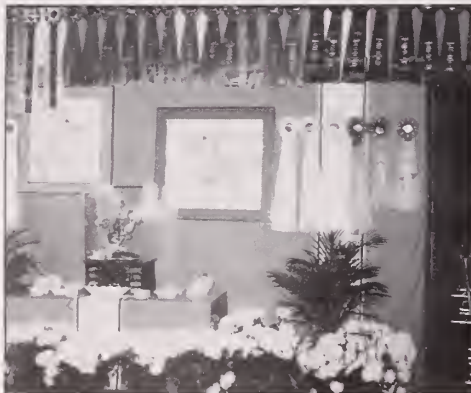
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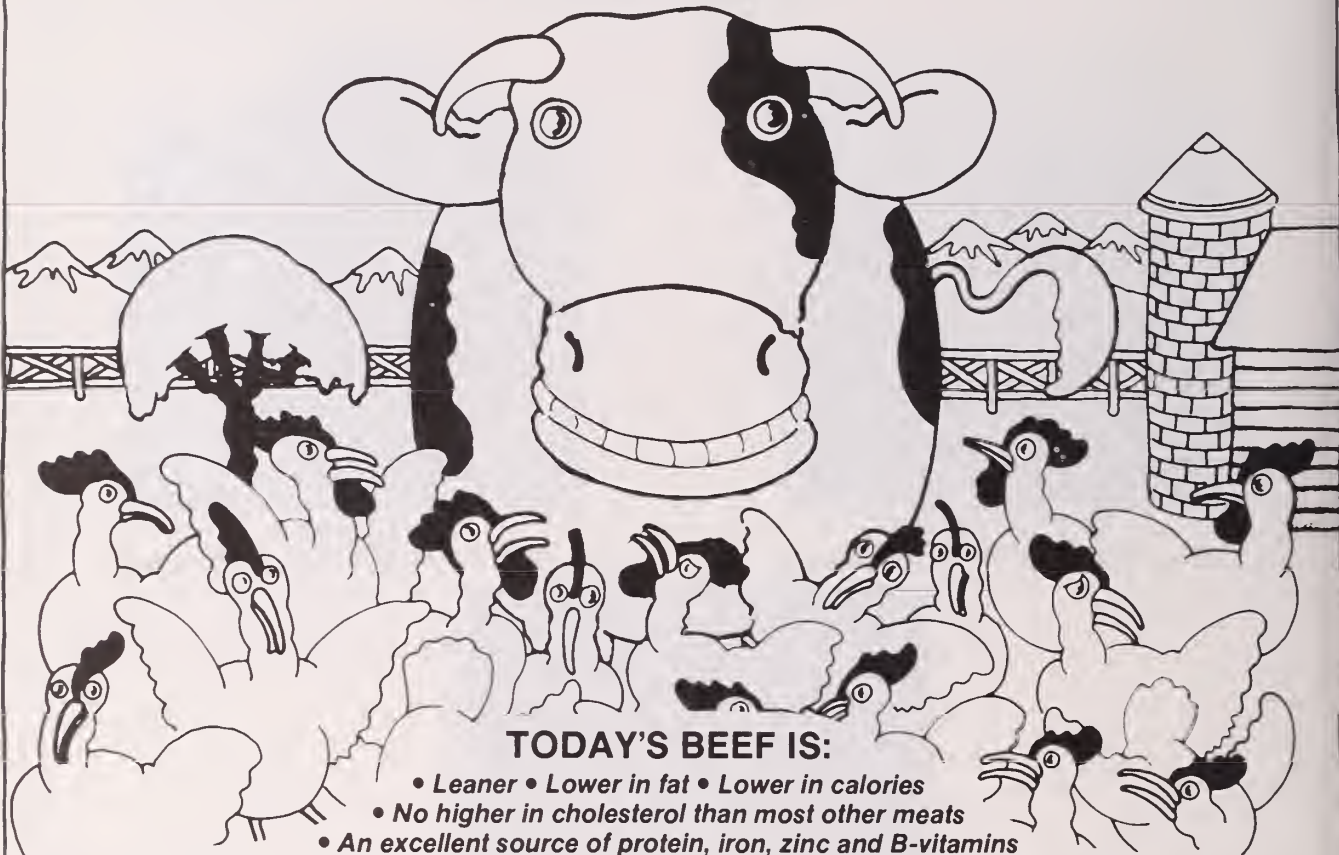
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Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

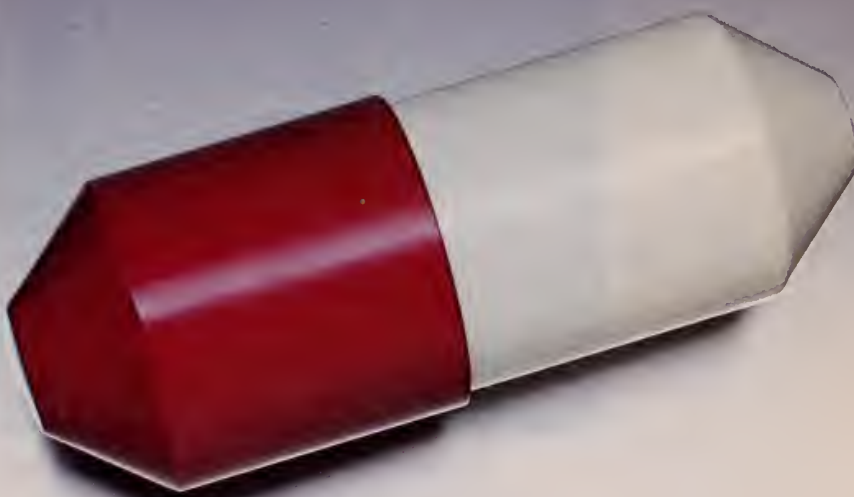
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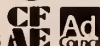
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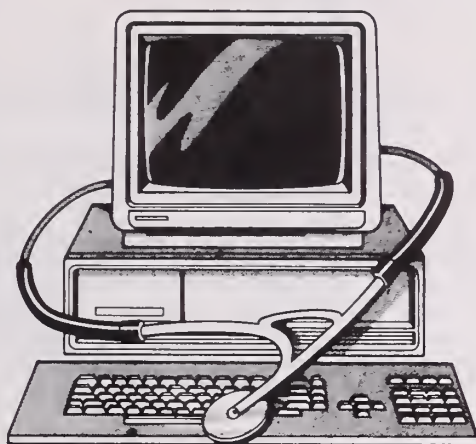


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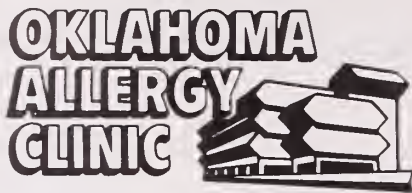
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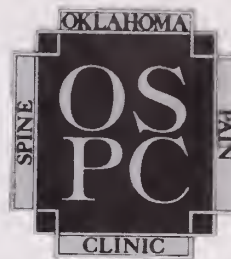
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## INDEX TO ADVERTISERS

The Arthritis Clinic .....	24A
City of Faith .....	1A
Cobblestone Park .....	322
Cooper Brothers .....	4A
Curtis 1000 Information Systems .....	17A
Edmond Medical Plaza .....	323
Eli Lilly Industries, Inc., ( <i>Ceclor</i> ) .....	2A
C. L. Frates & Co., Inc. ....	328
Glass-Nelson Clinic .....	22A
Harsha Orthopedic, Inc. ....	25A
Knoll Pharmaceutical Company ( <i>Isoptin</i> ) .....	6A-8A
McAlester Clinic .....	22A
Medical Arts Clinic of Ardmore .....	23A
Medical Arts Laboratory .....	20A
James B. Morris II & Associates .....	26A
Oklahoma Allergy Clinic .....	20A
Oklahoma Beef Commission .....	14A
Oklahoma Cardiovascular and Thoracic Surgery Associates .....	19A
Oklahoma City Clinic .....	1FC
Oklahoma Hand Surgery Center, Inc. ....	25A
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Oklahoma Plastic and Reconstructive Surgeons, Inc. ....	26A
Oklahoma Urology Center .....	25A
OMPAC .....	10A
Orthopedic & Arthritis Center .....	23A
Orthopedic Associates .....	24A
OSMA Council on Member Services .....	31A
PLICO .....	9A
Rehabilitation Institute of Oklahoma .....	320
Roche Products, Inc. ( <i>Dalmane</i> ) .....	IBC, BC
Shawnee Medical Center Clinic, Inc. ....	21A
SmithKline Beckman ( <i>Dyazide</i> ) .....	15A
Southern Plains Medical Center, Inc. ....	21A
Tulsa Adjustment Bureau, Inc. ....	330
The Upjohn Company ( <i>Motrin 800</i> ) .....	5A
Waldrop Bros., Inc. ....	324
Willow View Hospital .....	18A
Windy Meadow Farm .....	12A, 13A

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### Style

All manuscripts should adhere to the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual for Authors & Editors*. Footnotes, bibliographies, and legends for illustrations should be typewritten, double-spaced, on separate sheets. References are to be listed in the order of their appearance in the article.

### Illustrations

Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations should be labeled with the author's name and must be numbered in the order in which they are referred to in the article. The quality of all illustrations must be in keeping with the quality of the magazine.

### News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc, are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

### Reprints

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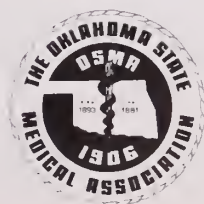
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September 18 Wednesday	New Employee's Workshop (all day)	Oklahoma City Lincoln Plaza
September 19 Thursday	New Employee's Workshop (all day)	Tulsa Sheraton Inn Skyline
October 19 Saturday	Workers' Comp Workshop (all day)	Oklahoma City The Centre
October 26 Saturday	Financial Planning Seminar (all day)	Oklahoma City The Centre
November 9 Saturday	Financial Planning Seminar (all day)	Tulsa Doubletree Hotel
November 13 Wednesday	Law for the Medical Office (all day)	Tulsa Sheraton Inn Skyline
November 14 Thursday	Law for the Medical Office (all day)	Oklahoma City The Centre
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For more information contact:  
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## THE LAST WORD

■ **Alexander Poston, MD, president, board of directors,** and chief executive officer of the Oklahoma City Clinic, was elected to the board of directors of the American Academy of Medical Directors during their Tenth National Conference on Health Care Leadership and Management in May. Dr Poston has been a member of the academy since 1979 and will serve on the board for three years.

■ **Ground was broken in June on a new \$1.8 million PruCare medical facility,** located on 3.4 acres of land in Midwest City. When completed next year, the 23,000-square-foot building will be the third PruCare medical facility in the Oklahoma City metropolitan area. Plans for the center provide for a second phase, which can add another fifty percent of square footage when needed. Two other PruCare centers have been serving of some 26,000 Oklahoma City Pru-Care members enrolled through 140 companies.

■ **For physicians who cannot attend one of the Saturday Loss Prevention Seminars** scheduled this month by the OSMA Council on Member Services, special make-up seminars have been set for 1 PM, Wednesday, August 28, and 1 PM, Saturday, September 7 at the Centre in Oklahoma City. In Tulsa, a make-up seminar has been scheduled for 1 PM, Saturday, September 21 at the Sheraton/Kensington Hotel. Space for these seminars is *very* limited. To register, please call the OSMA, (405) 843-9571.

■ **The AMA's inaugural National Medical Staff Conference** has been scheduled for October 17-19, 1985, at the Sheraton Washington Hotel, Washington, DC. The AMA has invited hospital chief executive officers, medical staff leaders, and chairmen of hospital governing boards to the meeting, which will address the critical need to improve the efficiency and effectiveness of the nation's hospitals. Participants will discuss ways to encourage cooperation between hospital physicians and hospital administrators to solve problems of mutual concern.

■ **The new, fully cumulative 1986 edition of *USAN and the USP Dictionary of Drug Names*** has

been published this summer by the United States Pharmacopeial Convention. It is the authoritative list of established names for drugs in the USA, conveniently collected in a single volume. The Federal Food and Drug Administration (FDA) said in November 1984 that interested persons may, in the absence of the designation of an official name, rely on *USAN and the USP Dictionary of Drug Names* for the established name for any drug in the US. It is the intent of the FDA that the US Adopted Names (USAN) and the compendial (USP and NF) names be the "established names." Those names constitute the main list and are printed in boldface type. Orders for the new edition of *USAN/USP DDN* should be addressed to the Order Processing Department, USP Convention, Inc, 12601 Twinbrook Parkway, Rockville, MD 20852. The price is \$54.95 per copy with quantity discounts for eleven or more copies.

■ **Two new consensus development statements** have been issued by the National Institutes of Health (NIH) as part of their ongoing series of reports from consensus development conferences. Free single copies of "Travelers' Diarrhea" and "Health Implications of Obesity" are now available from Michael J. Bernstein, Office of Medical Applications of Research, NIH, Building 1, Room 216, Bethesda, Maryland 20205.

■ **August 30 is the last day that special group rates on housing accommodations** will be available for the Oklahoma Physicians Thirteenth Annual Winter Seminar. The seminar, to be held at Copper Mountain, Colo, runs from December 27, 1985 to January 3, 1986. After September 1, persons attending the meeting will be responsible for making their own housing arrangements. The seminar is certified for AMA and other credit hours. The registration fee prior to September 1 is \$175; after that, it will be \$225. For information and/or registration call or write Contemporary Medical Educators, c/o Irwin H. Brown, MD, 5700 NW Grand Boulevard, Oklahoma City, OK 73112, (405) 946-0548.

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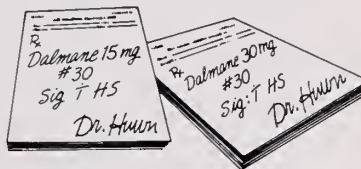
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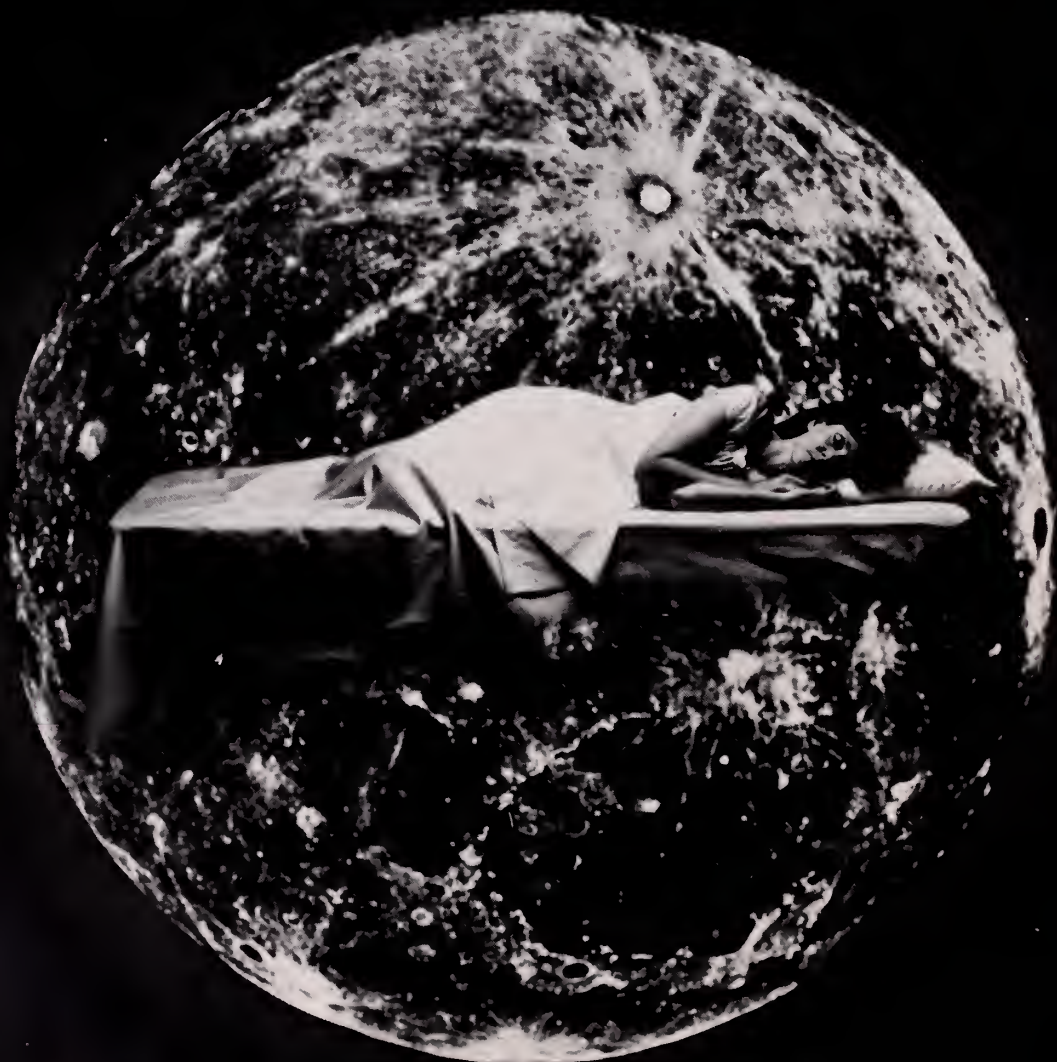
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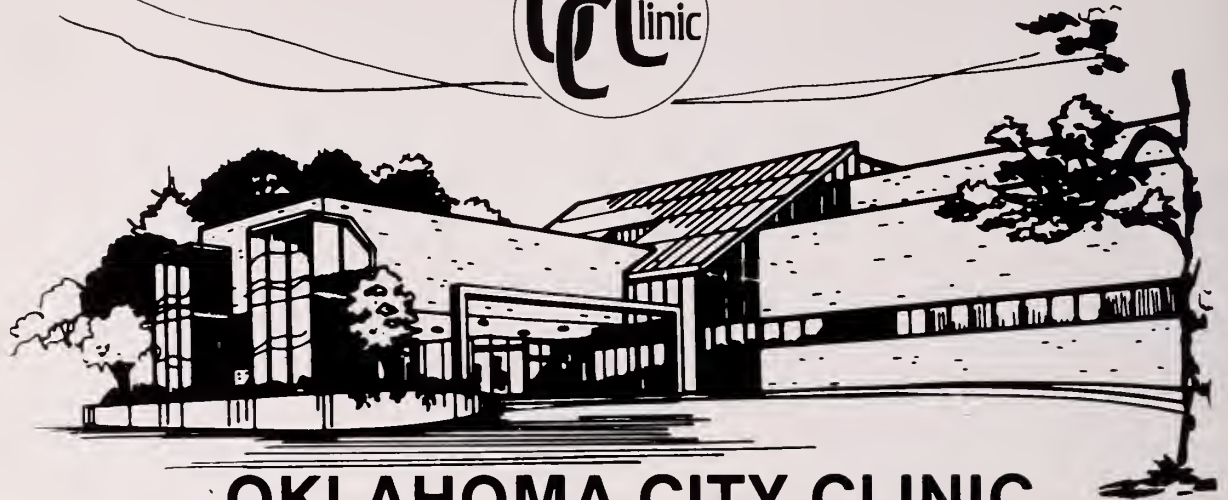


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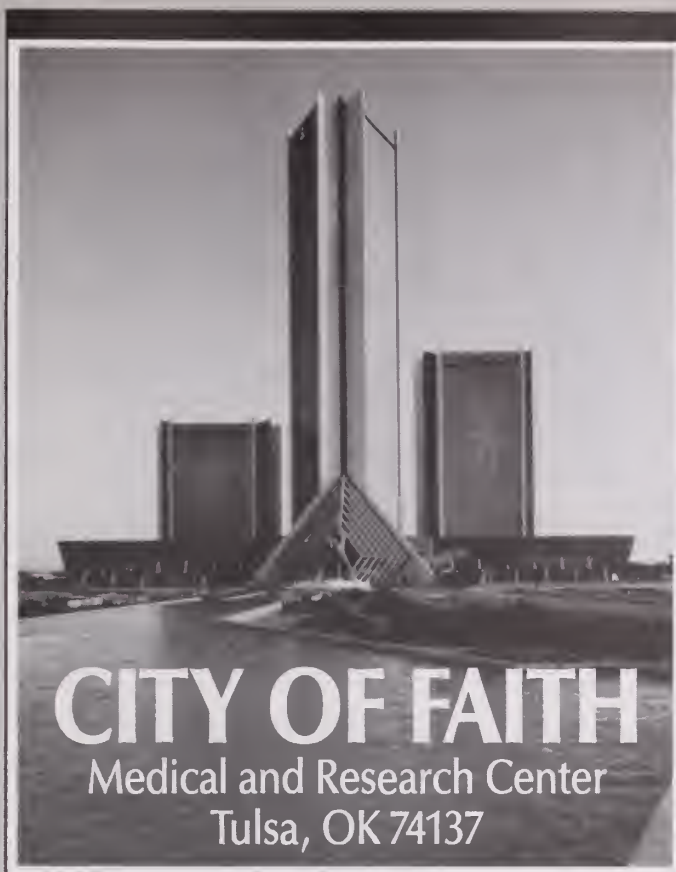
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# JOURNAL

*Oklahoma State Medical Association*

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#### EDITORIAL

- Now Now: The Premorbid Reflex ..... 337  
MARK R. JOHNSON, MD

- President's Page ..... 338  
ELVIN M. AMEN, MD

- Guest Editorial: A Student's View — A Changing  
Attitude in Changing Times ..... 339  
STEVEN SILVERSTEIN, MS IV

#### COMMENTARY

- The Future of Graduate Medical Education ..... 340  
EDWARD N. BRANDT, JR., MD

#### SCIENTIFIC

- Outpatient Cisplatin Chemotherapy in a Community  
Hospital Cancer Center ..... 343  
JAMES A. YOUNG, MD; SHARON SEGLER, RN

#### NEWS ..... 349

Hib study includes Oklahoma . . . Twenty-one Life Members  
named . . . Aspirin prevents Kawasaki complications . . .  
State's occupational therapists must be licensed . . . AMA  
issues child abuse guidelines . . . Oklahoma's HERO coming  
. . . Residents in Boston want "real world" skills . . . NIH  
reports on obesity and travelers' diarrhea.

#### DEPARTMENTS

- |                              |                         |  |
|------------------------------|-------------------------|--|
| State Department             | Index to                |  |
| of Health ..... 347          | Advertisers ..... 30A   |  |
| Deaths ..... 356             | Instructions            |  |
| In Memoriam ..... 356        | for Authors ..... 30A   |  |
| Reaction Time ..... 358      | Auxiliary ..... 31A     |  |
| Book Reviews ..... 359       | The Last Word ..... 32A |  |
| Miscellaneous Adv. . . . 362 |                         |  |

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## Now Now: The Premorbid Reflex

As I recall, the issue under consideration was the ethical aspect of accepting a flat fee for the professional care of patients. It was discussed in a meeting of the Oklahoma County Medical Society and the consensus achieved was to serve as the basis for a resolution to be introduced at the forthcoming meeting of the House of Delegates of the state medical association. It was about twenty years ago, and in a spate of zeal I stood up and suggested that to agree to such a proposition would amount to an admission that we were whores and predicted that we would then spend the rest of our lives haggling about our price. As I sat down the applause convinced me that our resolution would declare that participation in such an agreement was unprofessional and unethical. To this day that applause mystifies me. It must have been an expression of gratitude for the fact that I sat down. The resolution our society sponsored declared that the acceptance of fees determined without our participation would not be considered unprofessional or unethical and that such decisions would be made independently by the physicians facing them. I was disappointed, a bit incredulous, and more than a bit vocal.

Then it happened. A colleague approached me and with an expression of tolerant amusement on his face patted me on the shoulder and said, "Now now, Mark! It isn't all *that* bad. You'll get over it."

My first encounter with the elicited "now now reflex" became history.

Looking back I realize the malevolent portent of the now now reflex. It is a marker for the cascade of events which lead to impotence. It is a sign of epidemic indifference. It is the great mollifier, the brand of the seducer.

With intemperate vanity I admit that I am gifted with a talent for eliciting the now now reflex. I have evinced it a hundred times or more; in personal conversations, from a speaker's platform, and as a writer of editorials.

Whatever the setting and however disguised, the now now reflex always causes me some embarrassment. It reminds me of my ineffectiveness as a persuader. It illustrates that I have lost cadence with society. It makes me see that I am fighting a war that isn't even an argument.

In spite of these humbling influences, I am probably destined to continue to elicit the now now reflex with an unabating frequency. At least until no one will listen to what I say or read what I write or, at worst, give a damn what happens next. The latter eventuality is the most lethal of all the effects of the now now reflex.

Please, if any of you are tempted to respond by saying, "Now now . . .," don't. It really *is* all that bad. And I will *never* get over it.

—MRJ



Summer is at its peak; vacations are gone or going rapidly. It is time to aggressively face up to the future of medicine. California and Florida have won some legislative victories. Over 4,000 physicians and their families attended sessions at the Illinois legislature and succeeded in convincing legislators to take action to control medical liability problems. New York is facing catastrophic loss of physician services in major specialties unless legislative reform is obtained.



We Oklahoma physicians and surgeons must give active support to AMPAC and OMPAC in order to win support from our legislators.

Dig down, cough up, get involved, participate. Contribute more than you did; become a \$200-plus member, or even more.

Other states are winning legislative support. We can too.

Sincerely,

*Elvin M. Amen, M.D.*

## A STUDENT'S VIEW

# A Changing Attitude in Changing Times

STEVEN SILVERSTEIN, MS IV

As a student delegate to the American Medical Association, Steve Silverstein attended the AMA's June meeting in Chicago. He wrote the following commentary in the wake of that meeting.

Past history suggests that regardless of cultural differences, mankind is rather resistant to change. Even in this country, many political systems had been tried and failed before our founding fathers incorporated this behavior peculiarity into the model of checks and balances that has become the basis for our current form of government. In other words, progress (or at least change) must occur slowly in order to enjoy complete acceptance.

The medical profession also is deserving of this consideration, yet the changes which have recently been instituted in medicine (and those which threaten the future), have occurred practically overnight. Changes such as soaring malpractice rates, "alphabet soup" regulations and organizations including the DRGs and HMOs, and a boom in investor-owned hospitals are complicated by a surplus of physicians, an unsure economic stability, and an increasingly hostile group of legal professionals who are advertising around the country in an effort to encourage investigation into potential suits of malpractice.

Many doctors who have enjoyed a lifetime of self-regulation and success have met these changes with resentment and bitterness toward those third parties who are responsible for their institution, even though they recognize that the economics of medicine have clearly gotten out of hand. This resentment is not

completely without grounds, for it does appear that doctors are being punished for a "sick" economy in general, even though they have committed no wrong and, in fact, have maintained their dedication toward excellence in patient care.

With this background in mind, I feel that it is important to document the discouragement that students feel when we hear physicians warning us to reconsider our decision to enter the field of medicine "before it is too late." The motives by which we were driven to pursue a medical career have remained unchanged. Our desire to provide human services unlike those of any other profession has been increased in recent years by the many advances made in medicine, and, although the atmosphere in which these services are provided has become cloudy, the benefits we are able to offer to our patients remain perfectly clear. If we understand that the decision to become a physician carries with it a set of environmental circumstances which differ significantly from those of the past, we will not enter a lifetime of (medical) practice with preconceived bitterness toward the community we serve.

We ask those of you with whom we have the opportunity to work and learn to educate us about the current and future state of affairs in medicine. Demonstrate the changes that have occurred, and suggest what we may do to meet the changes that lie ahead. Remember, it is you, our family doctors, professors, friends, and relatives, who have been and continue to be our models, our mentors, and our heroes. □

From the University of Oklahoma College of Medicine, Oklahoma City  
Steven Silverstein, 2049 Northwest 47th Street, Oklahoma City, Oklahoma 73118.



## The Future of Graduate Medical Education

EDWARD N. BRANDT, JR., MD

**Dr Brandt, chancellor of the University of Maryland at Baltimore and an alumnus of the University of Oklahoma College of Medicine, was a guest speaker at the OSMA's Annual Meeting in May. This is the text of his address to the medical students who attended that meeting.**

**H**aving graduated from the University of Oklahoma Medical Center in 1960, some twenty-five years ago, I have been privileged to see some of the greatest advances in medicine in the history of man. The capabilities of physicians have been increased beyond any reasonable expectation. Students and residents are entering a medical career at an exciting time. The potential to help patients will certainly improve over the next twenty-five years to a far greater extent than it has over the past twenty-five. A career in medicine is very satisfying and, in spite of current ordeals, it should remain so.

My purpose is to discuss the future of graduate medical education. Let me begin by stating the obvious fact that I have no direct pipeline to the future. My only justification for writing on this subject is that I have just recently completed four years making federal health policy, and I now serve as the Chief Executive Officer of a large university with a major commitment to health care and health professional education.

With that, let me turn to the subject at hand. First, graduate medical education is essential to our society. It is the way in which the American public gains an adequate supply of well-educated physicians

to provide care in the future. Our society understands that and will not let it be compromised. Second, let me put my remarks in perspective. I believe that graduate medical education is exactly what its name says it is, education. Its purpose is to provide an education for physicians, to prepare them to provide specific kinds of health care to people. Residents are in those programs to gain an education. It is a fact that residents deliver health care, but that is not their primary purpose. That point is critical in considering the future.

The fundamental issues are what types of graduate medical education to provide, how much, and how should it be funded? Those are important questions and they deserve an answer . . . an answer that not only meets expert assessments, but also can be supported by our society because, either directly or indirectly, graduate medical education will occur at societal expense.

As of May, 1985, a debate is underway in Congress over graduate medical education. In my view, it is unfortunate that this debate is occurring in the wrong arena, namely, as a part of the Medicare considerations. Appropriate control of Medicare expenditures is a reasonable goal. As a part of achieving that goal, it is also reasonable to debate Medicare expenditures for education. However, please recall that Medicare is a system of health care reimbursement. The purpose underlying Medicare is to assure access to quality health care for those elderly persons who are eligible. Irrespective of your views about Medicare, it is clear that the US government has made a commitment to the eligible elderly of this country to assure them access to health care. As such, the Med-

Edward N. Brandt, Jr., MD, Office of the Chancellor, University of Maryland at Baltimore, 520 West Lombard Street, Baltimore, Maryland 21201.

icare system has an obligation to assure an adequate supply of health care professionals to meet that commitment. Hence, educational costs are clearly justifiable. However, the reimbursement system should not be the mechanism by which we set manpower policy for this country. Medicare funding levels for graduate medical education should not be decided on the basis of manpower policies for all of our society. It is quite reasonable for the Medicare debate to include discussion of those physicians who will be most needed to meet Medicare's commitment to the elderly. Therefore, limiting Medicare funding for graduate medical education programs to specific specialties is a reasonable policy *if* it is based upon a determination of the future needs of the Medicare beneficiaries.

Not only is graduate medical education being debated in the Congress as they look at Medicare funding, but it is also being debated by hospital groups, by insurance companies, by the new health care delivery systems such as preferred provider organizations (PPOs), health maintenance organizations (HMOs), and others. Traditionally, in this country, graduate medical education has been funded as a hospital expenditure. However, as medicine advances, it is clear that fewer and fewer patients will require hospitalization and the role of the hospital in the health care delivery system is currently under careful review. It should be clear that all of these organizations have a great interest in the future of graduate medical education. HMOs, PPOs, and so forth need physicians in order to meet their commitments to their patients. My prediction is that all of them will begin to participate directly or indirectly in graduate medical education.

My personal view is that graduate medical education should continue to be paid from patient fees. In our society, the cost of all goods and services includes funds for education. For example, when you buy an airline ticket, a portion of the price is for education of the pilots, flight attendants, and mechanics. As a frequent airline passenger, I am delighted to pay that educational expense.

**W**hat is the alternative to graduate medical education funding from patient charges? The one most discussed is direct tax funding. That frightens me, for government funding brings government intervention and controls — most of which will be negative. Furthermore, tax-dollar funding tends to be inconsistent and a function of changing congressional or legislative priorities. Graduate medical education should be in the hands of educators, not legislators.

I believe we will, as a society, work out the issues of funding graduate medical education. I wish I knew how because it would ease a great deal of my anxiety.

Will there be an adequate supply of graduate medical education positions in the future? In my judgment, there is no question about that. However, I would suggest to you that there will be some shifts in the types of graduate medical education that are offered. I believe there will be much greater emphasis on the primary care specialties and decreased emphasis on the surgical specialties. Furthermore, I anticipate that there will be less emphasis on inpatient sites for this education. There will be more ambulatory-care teaching sites developed and greater emphasis on ambulatory care. Furthermore, I antici-

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paid from  
patient fees.**

---

pate that there will be a much greater emphasis on the quality of those educational programs. Greater attention will be focused on the selection of the residents and on their evaluation throughout the program.

Some would question my predictions about the specialty distribution. They would emphasize the fact that primary care residencies, especially family medicine, have not been filled for the last two years. What good will it do to increase positions if graduates do not select them?

I have several reasons for making the above predictions. First, the public wants more primary-care practitioners, and will insist on getting them. The second reason is more complex, and is based upon the following considerations. The Graduate Medical Education National Advisory Committee (GMENAC) study predicts an oversupply of physicians by the year 2000. This prediction was based upon their perceptions of the medical needs of the American population. The prediction of an oversupply of physicians extended to virtually every specialty except the three comprising primary care, family medicine, internal medicine, and pediatrics. For those, a deficit was predicted. Recent studies in my state of Maryland, and I understand, in Oklahoma, led to similar results. During the past four years, I have been privileged to travel over much of this country and talk to physicians, business and political leaders, and citizens. Everywhere, I heard the same story. I am convinced,



and the data support this, that we will experience an excess of physicians by 1990 — indeed, in many parts of the country it is already true. Nowhere is there an excess of primary care physicians.

In addition, remember that the GMENAC predictions were based upon need, but medicine is demand based. Americans can and do demand services that, strictly speaking, are not required. Most of those are primary care services. Comprehensive care is the best we have to offer, and that is the essence of primary care.

I believe that graduates of medical schools can read the same reports that I do and that they will see the brightest future to be in primary care.

At the same time, those who elect to enter other specialties can be assured that the public wants and needs good physicians. You must select that specialty that brings you the greatest personal satisfaction and permits you to be of the greatest service to people.

**I**n summary, my long-term view of the situation is that graduate medical education is healthy and that we will come out of this current debate with a system even stronger than the current one. Many are concerned about the short term. The short term is a little harder to predict because we are in a situation in Washington where Congress is desperate to cut spending to decrease the current deficit. As a consequence, some short-term decisions may be made that could have a negative impact, at least on some programs. On the whole, though, I do not anticipate the shortage of graduate medical education positions that many others have predicted. The major reason is that much of the pressure on the number of physicians has been due to the influx of American foreign medical graduates (USFMGs). There seems to be no doubt that all parties are now convinced that this is

not good for graduate medical education or for the health care delivery system. Hence, there is legislation in Congress that would limit Medicare funding to only those positions that are filled by American graduates. Furthermore, there has been a tightening up by accreditation bodies so that those programs that have relied upon foreign medical graduates (either aliens or American citizens) are receiving greater scrutiny than ever before. Since there is clearly a need to have the best educated physicians possible delivering health care, and since there is a choice, the pressure for positions due to USFMGs will diminish, making the prospects for American graduates even brighter.

Clearly, there will still be pressure in some specialties. The surgical specialties, in particular, will remain crowded over the short term. But I don't see that as a crisis. At the same time, many hospitals with falling patient censuses, and therefore decreasing revenues, are evaluating the number of house-staff officers that they can accept; but other systems for the delivery of health care are looking at ways to get into graduate medical education because of their need for physicians for the future. I believe that there will be more programs created than are lost although, again, there may be some specialties hit harder than others.

In summary, I am convinced that the future for graduate medical education is bright and secure. Some may not be able to enter the specialty of their first choice. That is unfortunate, but that has also been true for many years. All graduates will be able to obtain a graduate medical education position, continue their education, and deliver quality health care to their patients. Physicians have a bright future, and a secure future, but it will certainly be different from the past. □

To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.

— Sir William Osler

# Outpatient Cisplatin Chemotherapy in a Community Hospital Cancer Center

JAMES A. YOUNG, MD, and SHARON SEGLER, RN

We retrospectively reviewed the records of 105 patients receiving cisplatin chemotherapy in a community hospital's medical oncology practice between January 1, 1982, and December 31, 1983. A total of 543 cycles of chemotherapy were administered, with 454 (84%) given in a specially equipped and staffed outpatient cancer center. Twenty (19%) patients required delayed hospitalization for chemotherapy toxicity. Twenty-nine (28%) patients did not complete the planned treatment course due to chemotherapy toxicity or patient refusal to continue therapy. Outpatient cisplatin chemotherapy reduces costs by a minimum of \$375 per cycle by comparison with inpatient therapy. Administration of complex chemotherapy in a regional outpatient cancer treatment center decreases the cost of care without sacrificing safety or patient comfort.

Cisplatin is a commonly used antineoplastic agent active against a variety of human neoplasms. The drug plays a pivotal role in the treatment of ovarian and testicular neoplasms, and has significant activity in head and neck, bladder, esophageal, cervical, and lung cancer.<sup>1</sup> Commonly observed toxicities of cisplatin include nausea and vomiting, impaired renal function, myelosuppression, high-frequency hearing loss, and peripheral neuropathy.<sup>2</sup>

Because of the potentially formidable side effects of cisplatin, techniques of administration are relatively complex. Early cisplatin trials demonstrated that high volumes of intravenous fluid with mannitol and/or furosemide diuresis lessened the renal tubular

damage.<sup>2-4</sup> Recently, complex antiemetic programs incorporating high-dose metoclopramide have been successful in reducing the incidence of disabling nausea and vomiting.<sup>5</sup> As a result, specialized nursing and pharmacy support is required in order to administer the drug safely and with minimum side effects. In many cancer treatment centers, this results in routine and repeated hospitalization of patients for cisplatin chemotherapy. In other centers, outpatient administration of cisplatin has been documented to be safe and well tolerated by patients.<sup>6,7</sup>

In our community hospital-based cancer center, cisplatin chemotherapy has been administered in the outpatient clinic in the vast majority of patients. The goal of this retrospective audit of our cisplatin chemotherapy experience was to estimate the toxicity of cisplatin-based chemotherapy in our practice, ascertain the frequency with which hospital admission is required, study the reasons for aborting chemotherapy, and perform a cost comparison of outpatient versus inpatient chemotherapy administration in our clinical setting.

## Materials and Methods

**Facility.** The Natalie Warren Bryant Cancer Center is an outpatient cancer treatment facility affiliated with Saint Francis Hospital in Tulsa, Oklahoma. The center houses a radiation therapy facility staffed by three radiation therapists and a medical oncology department staffed by five medical oncologists. The center also has a diagnostic laboratory, a diagnostic radiology unit, and an outpatient pharmacy equipped

James A. Young, MD, Natalie Warren Bryant Cancer Center, Saint Francis Hospital, 6161 South Yale, Tulsa, Oklahoma 74136.



Table 1. — Patient Characteristics (105 Patients)

<b>Sex</b>		
Male	33	(31%)
Female	72	(69%)
<b>Residence</b>		
Tulsa	50	(48%)
Other	55	(52%)
<b>Primary Site</b>		
Ovary	53	(50%)
Lung	20	(19%)
Head/Neck	6	( 6%)
Testis	5	( 5%)
Cervix	3	( 3%)
Other	18	(17%)
<b>Age</b>		
20-29	3	( 3%)
30-39	9	( 9%)
40-49	18	(17%)
50-59	34	(32%)
60-69	26	(25%)
70-79	14	(13%)
80-89	1	( 1%)

Table 2. — Details of Chemotherapy

Single agent	18	(17%)
Combination	87	(83%)
Mean number of cycles	5	(range 1-16)
Median cisplatin dose (mg/M <sup>2</sup> )	50	(range 20-120)
<b>Cycle 1</b>		
Inpatient	42	(40%)
Outpatient	63	(60%)
<b>All cycles</b>		
Inpatient	89	(16%)
Outpatient	454	(84%)
<b>Toxicity requiring hospitalization</b>		
GI/malnutrition	11	(11%)
Myelosuppression	6	( 6%)
Pulmonary	2	( 2%)
Renal	1	( 1%)
Total	20	19%

for chemotherapy preparation. The medical oncology area has four private bedrooms for administration of complex chemotherapy programs or blood transfusions and is staffed by seven nurses with oncology nursing training. The center handles approximately 25,000 outpatient visits annually.

**Patients and Study Design.** Medical Oncology records of patients seen between January 1, 1982, and December 31, 1983, were reviewed for patients receiving cisplatin chemotherapy, either alone or in combination with other antineoplastic agents. During the study interval, 1,486 new patients were seen in the medical oncology section of the cancer center. We identified 105 patients who received cisplatin chemotherapy. Charts were retrospectively reviewed by one coauthor (oncology nurse and data manager) with a data collection form designed to retrieve information including patient's sex, age, tumor type, and residence; chemotherapy dose, route, and number of cycles; and nature of chemotherapy toxicities. In addition, based upon information available in the chart, a judgment was made as to the primary reason for stopping treatment. Information from these data collection forms was then collated and analyzed.

**Chemotherapy technique.** With few exceptions, patients were treated according to a standardized schema designed to allow timely and safe administration of cisplatin chemotherapy in the outpatient clinic. Prior to each cycle, complete blood counts (CBCs) and creatinine serum levels are determined to establish the presence of adequate bone-marrow and renal function. Via a peripheral intravenous line,

patients receive 1,000 cc of 5% dextrose/.45 normal saline with 15 meq/l KCl over a period of two hours. This is followed immediately by a 20 mg bolus of furosemide administered intravenously and 12.5 gms of mannitol administered intravenously over a period of twenty minutes. Concurrently, the prescribed dose of cisplatin, mixed in 1,000 cc of 5% dextrose/.45 normal saline, is infused over a period of two hours. Antiemetics and other intravenous antineoplastic agents are administered at the discretion of the attending physician. The total treatment time is approximately four hours. No special efforts are made to monitor the patients for urine output.

**Cost Analysis.** The comparison of hospital charges for inpatient versus outpatient chemotherapy is based upon several assumptions. The laboratory charges are for a CBC and a serum creatinine test. The pharmacy charges are for 100 mg of cisplatin; the prescribed intravenous fluids, furosemide, and mannitol; and a hypothetical intravenous antiemetic regimen employing two 150 mg doses of metoclopramide and a single 25 mg dose of diphenhydramine. The inpatient room charge assumes a one-day stay. Physician charges are the usual and customary fees allowed by Medicare for a single outpatient chemotherapy visit or for the admission-day and discharge-day management of a patient admitted to the hospital for an overnight stay for cancer chemotherapy.

## Results

Table 1 details the characteristics of the 105 patients

**Table 3. — Primary Reason for Stopping Therapy**

End of planned course	32	(30%)
Progression of tumor	44	(42%)
Lost to follow-up	4	( 4%)
Toxicity	25	(24%)
Lung	2	( 2%)
Gastrointestinal	4	( 4%)
Neuropathy	6	( 6%)
Renal	1	( 1%)
Patient Refusal (multiple reasons)	12	(11%)

studied. The median age of our patients was 57 years, with a range of 20 to 81 years. Approximately 52% of the patients were from outside the immediate Tulsa metropolitan area and required transportation from some distance in order to come to the cancer center for treatment. Patients with ovarian cancer (50%) and lung cancer (19%) comprised the largest categories of patients receiving cisplatin during the study period.

As indicated in Table 2, the majority (83%) of our patients received cisplatin in combination with other antineoplastic agents. The mean number of cycles administered was 5, and the median dose of cisplatin administered per cycle was 50 mg/M<sup>2</sup> body surface area. Of the patients studied, 40% received their initial cycle of chemotherapy while in the hospital. This reflects the fact that most patients began treatment while in the hospital for a diagnostic or staging evaluation. After cycle one, 90% of all treatment cycles were given in the outpatient clinic. Overall, 84% of a total of 543 cycles of chemotherapy were given in the outpatient clinic.

Some degree of gastrointestinal toxicity was seen in virtually all patients. For the purposes of this study, patients requiring hospitalization after chemotherapy were judged to have had severe or potentially life-threatening side effects. As noted, approximately 19% of patients required hospitalization for management of toxic reactions at least once during their treatment course. The most common cause of hospitalization following cancer chemotherapy was refractory nausea and vomiting and/or malnutrition (eleven patients). Hospitalization for management of neutropenia and fever or thrombocytopenia and bleeding was required in six patients, all of whom received cisplatin in combination with other myelosuppressive drugs. Two patients receiving cisplatin-based combination chemotherapy required hospitalization for management of toxic pulmonary symptoms thought to be unrelated to cisplatin. One patient with metastatic squamous cell carcinoma of the penis and bilateral ureteral obstruction was admitted with tumor progression and acute renal failure, possibly

**Table 4. — Cost Comparison  
Inpatient Versus Outpatient Cisplatin Chemotherapy**

Cost Category	Inpatient	Outpatient
Laboratory	68.00	36.75
Pharmacy	558.90	558.90
Room	177.00	30.00
Nursing	107.00	29.00
IV supplies	28.20	28.20
Subtotal	939.10	682.85
Physician fee (Medicare)	145.00	26.25
Total	1,084.10	709.10

related in part to cisplatin chemotherapy. No other instances of significant renal failure were observed.

Table 3 details the primary reason for discontinuation of therapy in our patients. The reason most commonly encountered was disease progression (42%). Another 30% of patients completed the planned course of chemotherapy. In 28% of all patients treatment was stopped because of patient refusal, patient failure to return, or evidence of severe chemotherapy toxicity.

A cost comparison of inpatient versus outpatient treatment (Table 4) demonstrates that there is a savings of 35% or \$375 per treatment cycle in favor of outpatient chemotherapy.

## Discussion

Cisplatin is currently one of the most useful agents in the armamentarium of antineoplastic drugs. The drug is routinely employed in some centers as part of combination chemotherapy for palliation of metastatic lung cancer, and wide acceptance of this application alone would expand enormously the number of cancer patients receiving cisplatin. Within the recognized limits of a retrospective study, we believe that this audit yields important information regarding the use of cisplatin cancer chemotherapy in a representative community cancer center, and several conclusions are warranted.

In our series, 28% of the patients discontinued treatment for reasons possibly related to toxicity (lost to follow-up, refusal to continue treatment, or symptoms of drug toxicity). In addition, 19% of all the patients, at some time during their course of treatment, required hospitalization for complications directly or indirectly related to cancer chemotherapy. In this group of patients with advanced neoplasia, the reasons for stopping treatment and for hospitalization are complex. Some of the toxicities were certainly related to other antineoplastic drugs given concurrently with cisplatin, and some of the toxicities were exacerbated by symptoms of metastatic neoplasia in poor performance-status patients.



Nevertheless, our experience underscores the potential for treatment-related hospitalization and premature discontinuation of treatment in patients treated with cisplatin-based chemotherapy.

Approximately 85% of all cisplatin chemotherapy cycles may be administered in the outpatient clinic regardless of patient age, distance from the cancer center, or tumor type. Although an occasional patient requires regular hospitalization because of unusually severe symptoms or signs of chemotherapy toxicity, the majority of patients find outpatient chemotherapy convenient and tolerable. It is not possible to ascertain from the data whether treatment-related morbidity, hospitalizations, and premature termination of therapy might have been minimized by offering all chemotherapy in the hospital. However, subsequent hospitalization for management of toxic effects was required in several patients who received chemotherapy in the hospital.

Cisplatin chemotherapy requires careful attention to fluid intake, diuresis, and control of nausea and vomiting in order to avoid dehydration and impairment of renal function. While hospitalization may be required for patients receiving high doses of cisplatin ( $\geq 90$  mg/M<sup>2</sup>), a prospective study has documented the safety of outpatient administration of lower doses of the drug.<sup>6</sup> At least one additional study determined that outpatient cisplatin administration by a trained staff was more accurate and potentially safer than inpatient treatment on a medical ward.<sup>7</sup>

Cisplatin chemotherapy may be given more economically in the outpatient clinic than in the hospital. Based upon an estimated minimum savings of \$375 per cycle for 454 cycles of chemotherapy given

in the outpatient clinic, there was an estimated savings of \$170,250 over a two-year period for patients and their third-party carriers. In an era of cost consciousness and increasing scrutiny of utilization of hospital inpatient facilities, cancer chemotherapy represents an area where cost savings might be realized. This may require the establishment of regional outpatient cancer chemotherapy centers with specialized facilities, well-trained physician and nurse personnel, and appropriate laboratory and pharmacy resources. □

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*Sharon S. Segler, RN, specializes in oncology nursing. She was graduated from Tulsa's Hillcrest Medical Center School of Nursing in 1966.*

### Coming in October and November...

Among the manuscripts being considered for publication this fall are articles on the relationship of diet and hypertension, a report on a chronic illness and aging rehabilitation unit, and a case report on botulism. Already in production is the next story in the Leaders in Medicine series.



## Recommendations for *Haemophilus influenzae* Vaccine

A new vaccine to protect against *Haemophilus influenzae* type b (Hib) has recently been licensed by the Food and Drug Administration (FDA). It is expected the vaccine could potentially eliminate 20% to 25% of the disease, which is the leading cause of childhood meningitis and epiglottitis.

Children with certain medical conditions and those who attend day care centers are especially at risk of contracting Hib, or H flu. Researchers estimate that one of every 200 children in the United States will be infected with this bacterium before the age of five years.

The Oklahoma State Department of Health concurs with the recommendations of the Centers for Disease Control (CDC) that all children should receive the vaccine at twenty-four months of age. In high-risk groups, such as those in day care centers

and certain immunocompromised children, children as young as eighteen months of age may be given the vaccine. The vaccine also may be given to previously unvaccinated children through age five. It is not recommended for children under eighteen months of age.

### Related story, p 349

The Hib and DTP vaccines can be given at the same time at separate sites, since no impairment of the immune response to the individual antigens occurs under these circumstances.

The vaccine is not available at local health departments; therefore, it is recommended that parents consult their private physician to arrange vaccination.



DISEASE	June 1985	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	0	8	6	10
CAMPYLOBACTER INFECTIONS	48	145	96	—
ENCEPHALITIS, INFECTIOUS	1	13	11	12
GIARDIA INFECTIONS	26	108	96	—
GONORRHEA (Use ODH Form 228)	958	6102	5947	7183
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	21	114	103	—
HEPATITIS A	14	253	213	227
HEPATITIS B	16	102	83	120
HEPATITIS, NON-A NON-B	1	33	24	—
HEPATITIS UNSPECIFIED	3	37	52	101
MEASLES (RUBEOLA)	0	0	7	154
MENINGITIS, ASEPTIC	15	36	27	45
MENINGITIS, BACTERIAL				
(non-meningococcal, non H. Influenzae)	4	35	27	32
MENINGOCOCCAL INFECTIONS	2	20	23	21
PERTUSSIS	6	72	203	60
RABIES (Animal)	9	60	64	107
ROCKY MOUNTAIN SPOTTED FEVER	11	36	71	59
RUBELLA	0	1	0	1
SALMONELLA INFECTIONS	33	149	172	160
SHIGELLA INFECTIONS	30	99	84	122
SYPHILIS (Use ODH Form 228)	15	101	93	91
TETANUS	0	0	1	0
TUBERCULOSIS	22	133	122	159
TULAREMIA	2	7	11	11
TYPHOID FEVER	0	0	2	2

Diseases of Low Frequency	Total to Date This Year	
ACQUIRED IMMUNE DEFICIENCY SYNDROME	2	
BRUCELLOSIS	3	
LEGIONNAIRES DISEASE	5	
MALARIA	1	
REYE SYNDROME	2	
TOXIC SHOCK SYNDROME	6	
RABIES		
CRAIG	Skunk	1
KIOWA	Skunk	1
LOGAN	Skunk	1
LOVE	Skunk	1
MUSKOGEE	Skunk	1
ROGERS	Skunk	1
TILLMAN	Skunk	2
TILLMAN	Cow	1



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## Study using rifampin for Hib includes children in Oklahoma

Spread of *haemophilus influenzae* type b (Hib), the most common cause of bacterial meningitis in the United States, can be checked in day-care centers by administration of rifampin to classroom contacts, according to a multiclinic study.

The study of a cohort of children in Seattle, Atlanta, and the State of Oklahoma suggests that the risk of secondary disease (contraction of *haemophilus* by other children after classroom identification of a

primary case) is strongly age related, with virtually all of the secondary cases occurring in children younger than 23 months of age.

In the July 26 issue of the *Journal of the American Medical Association (JAMA)*, David W. Fleming, MD, of the Centers for Disease Control (CDC) in Atlanta, and colleagues point out that children older than 24 months can be vaccinated against *haemophilus*, but that the vaccine is not effective with children younger than 24 months of age. "These children may be at substantial risk for secondary Hib disease," they say.

The children are at even greater risk if they attend day care more than 25 hours per week, study results suggest. Thus, a strategy other than vaccination is needed to prevent spread of disease.

"Our study provides evidence that, in practice, administration of rifampin to the high-risk, otherwise-unprotected day-care attendees aged 0 to 23 months significantly diminishes their risk of secondary day-care-associated Hib disease," the researchers assert.

A new strategy for disease control has become imperative because of the large numbers of youngsters attending day-care centers. Each year there are

### Years of service recognized

## OSMA Board of Trustees names Life Members at May meeting

Twenty-one new Life Members were named by the OSMA Board of Trustees at their May 1 meeting in Oklahoma City.

Life Members from Oklahoma City are George S. Bozalis, MD; W. Turner Bynum, MD; Hugh M. Conner, Jr., MD; John R. Danstrom, MD; Robert R. Dugan, MD; Louis S. Frank, MD; Raymond F. Hain, MD; Muriel E. Hyroop, MD; Robert W. Kahn, MD; Willis E. Lemon, MD; Renee W. Papper, MD; William B. Renfrow, MD; and Helen Hughes Schmidt, MD.

New Muskogee Life Members are: James L. Green, Jr., MD, and Chester W. Mengel, MD.

Also named were Jon M. Chenette, MD, Okmulgee; Charles S. Cunningham, MD, Poteau; Claude B. Knight, MD, Wewoka; Earl I. Mulmed, MD, Tulsa; Paul T. Powell, MD, Ponca City; and Gerald M. Steelman, MD, Stillwater.

To be eligible for a Life Membership, an OSMA member must meet one or more of the following qualifications: (1) Be retired from the active practice of medicine due to ill health or age; (2) Be engaged in the active practice of medicine for fifty years or more; (3) Be seventy years of age or older. ☐

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### Related story, p 347

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an estimated 12,000 cases of Hib-caused bacterial meningitis in the US, the researchers point out. "Non-meningitic invasive Hib diseases account for a similar number of illnesses," they add.

"Although spread of Hib disease from one person to another was once thought to be rare, a number of recent studies have demonstrated that the risk of secondary disease among household contacts is substantially elevated." Other studies had suggested that rifampin might prevent secondary cases, the researchers say. Their study confirms that suggestion, they conclude. ☐



# Report says high aspirin doses prevent Kawasaki complications

Coronary aneurysms, which can cause heart attack and death in children with Kawasaki disease, may be prevented by high doses of aspirin, according to a study done by Gideon Koren, MD, and colleagues of the University of Toronto.

They compared coronary artery involvement in two groups of children with Kawasaki disease. Thirty-six children received acetylsalicylic acid, 80-180 mg/

kg/day, and 18 did not (fever in those 18 nontreated patients was controlled mainly by acetaminophen). "There were significantly more cases of coronary involvement in the nontreated group (50%) than in the salicylate-treated group (16.6%) and of coronary aneurysms (39% vs 3%)," the researchers report.

"Although salicylates have the potential advantage of providing both antiinflammatory and antiplatelet effects in Kawasaki disease," say the researchers, "their ability to prevent coronary aneurysms has not been documented in the past." The disease most often occurs in children between the ages of 6 months and 4 years. Symptoms include fever, sore throat, redness and swelling of extremities, rash, and swollen lymph nodes. It remains a difficult disease to diagnose, and the cause is unknown.

The researchers add that while fever is present, the absorption of salicylates is hindered, so it is important to maintain a high dose during that time. As fever subsides and absorption improves, the dose may have to be adjusted to avoid systemic toxicity. Because of the frequent delay in diagnosis, high-dose salicylate treatment may likely be postponed. The researchers caution against this: "Based on our findings, it is conceivable that the risk of not treating the disease during the febrile phase far outweighs the potential risks of high-dose serum concentrations of salicylates, which can be monitored daily."

Commenting editorially in the *Journal of the American Medical Association (JAMA)*, Aug 9), David M. Bell, MD, of the University of Tennessee, Memphis, says the study by Koren and colleagues presents important new data regarding a perplexing disease. He describes what is known about Kawasaki disease: that it was first described in the 1960s in Japan, and that children of Asian ancestry have the greatest risk, followed by blacks, then whites. The disease is most likely to occur in late winter or early spring, and there is no evidence of person-to-person contact or of a common source of exposure.

Bell says physicians can help research efforts by reporting cases promptly to the Centers for Disease Control through their local and state health departments so that trends can be monitored and further investigation undertaken. □

## Check your records

### Occupational therapists must be licensed, says Oklahoma law

In November, 1984, SB557 became law, thus requiring that all individuals calling themselves Occupational Therapists and/or practicing occupational therapy and/or rendering occupational therapy services must be licensed by the Oklahoma State Board of Medical Examiners.

Occupational therapy, by definition in the Oklahoma law, is:

... a health profession for which practitioners provide assessment, treatment, and consultation through the use of purposeful activity with individuals who are limited by or at risk of physical illness or injury, psycho-social dysfunction, developmental or learning disabilities, poverty and cultural differences or the aging process, in order to maximize independence, prevent disability, and maintain health. Specific occupational therapy services include but are not limited to the use of media and methods such as instruction in daily living skills and cognitive retraining, facilitating self-maintenance, work and leisure skills, using standardized or adapted techniques, designing, fabricating, and applying selected orthotic equipment or selective adaptive equipment with instructions, using therapeutically applied creative activities, exercise, and other media to enhance and restore functional performance, to administer and interpret tests which may include sensorimotor evaluation, psycho-social assessments, standardized or nonstandardized tests, to improve developmental skills, perceptual motor skills, and sensory integrative function, and to adapt the environment for the handicapped. These services are provided individually, in groups, or through social systems.

If you have individuals on your staff who are providing occupational therapy services as defined above and who are not licensed, information and applications are available from the Board of Medical Examiners office at 5104 N. Francis, Suite C, Oklahoma City, Oklahoma 73118, or by calling (405) 842-5674. □

October 1  
is the closing date  
for the  
November JOURNAL.

# AMA issues guidelines to aid in diagnosis of child abuse

Guidelines aimed at helping physicians diagnose and treat various forms of child abuse and neglect are offered by the AMA Council on Scientific Affairs in the August 9 issue of the *Journal of the American Medical Association (JAMA)*.

Each year more than one million children are seriously abused by their parents, guardians, or other adults, the council report states. Of those children, between 2,000 and 5,000 die as a result of their injuries, the report adds.

"Children with injuries inflicted on them by their caretakers are difficult for physicians to treat," says Douglas A. Sargent, MD, JD, chairman of the council panel that prepared the report. "As we try to diagnose and treat them, we have to struggle with our own feelings, hardly able to believe that parents could savage their children, yet bring them to us for repair."

Under state laws, physicians must now report suspected cases of abuse and neglect. They are afforded legal immunity to protect their reporting but face legal sanctions for failure to report. Thus, the guidelines hold promise of help not only for abused children and their disturbed caretakers but for physicians as well.

Several identifying factors for families and children at risk for abuse are listed in the report. Vulnerable families include those that are socially isolated, that suffer drug and alcohol abuse, and that have parents who strike one another or in which the parents were abused themselves as children. Vulnerable children include those who were born prematurely, have adolescent parents, were hospitalized for a prolonged period at birth, and are colicky.

Signs of physical abuse include bruises and welts to various parts of the body, patterned burns, certain types of fractures, lacerations, and abdominal injuries. Signs of sexual abuse include venereal diseases, recurrent urinary tract infections, vaginal discharge, and lax rectal tone. Signs of emotional maltreatment include failure to thrive, apathy or depression, and delays in physical development.

Also included are guidelines aimed at schooling physicians on how to interact with children and families in suspected cases. When interviewing the child, for example, physicians should conduct the interview in private, explain the purpose of the interview to the child in language appropriate to the youngster's age, and acknowledge the child's distress and lack of fault. Physicians also should advise parents of the legal obligation to report suspected cases, explain further actions that may be required, answer questions honestly, and attempt to be objective.

The report also advises physicians to expand their

roles beyond detection, diagnosis, and treatment. "Physicians can participate in the primary prevention of child abuse as well," the report says. "Expanded well-baby care, augmented information and education, and referrals to community resources may be provided for 'high-risk' parents. Physicians also may participate in changing hospital childbirth procedures to facilitate parent-infant bonding and support early education in child development and care."

Other preventive strategies should be aimed at reducing the burden of child care, family isolation, and long-term consequences of poor parenting. "Increased access to health and social services for all family members is another goal of any prevention effort," the report concludes. □

## *Oklahoma Health Center: The inside story*

### Oklahoma's *HERO*, arriving in November, raises expectations

*HERO, An Oral History of the Oklahoma Health Center*, written by Robert C. Hardy, executive for the Oklahoma Health Sciences Foundation, is expected to be available November 1.

The book, described by its author as a "narrative history" of Oklahoma City's vast health sciences center, traces the development of the complex from a small group of eight buildings in 1964 to the sprawling network of facilities in place today.

The title *HERO* refers to the bond issue passed in 1968, called "Health and Education for a Richer Oklahoma," which provided the \$31 million in capital funds that touched off the center's explosive growth and development. The chronicle of that development represents some three years of research and writing, including interviews with 150 of the principals involved.

*HERO* will be published by Western Heritage Books of Muskogee. □

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## Residents in Boston want more emphasis on "real world" skills

More training in basic skills, including history taking and physical examination, is needed in residency programs, say recent graduates in Boston. Less drilling in certain technical procedures also would improve medical training for "real world" practice, surveyed physicians add.

Conducted by Donald C. Kern, MD, MPH, and colleagues from Boston University School of Medicine, the study was aimed at strengthening the school's residency program in internal medicine. Surveyed were 61 recent graduates, 56 of whom responded to a detailed questionnaire. At issue was the difference, if any, between training received and skill sets used in real-world practice.

Among survey findings published in the *Journal of the American Medical Association*: 95% of the physicians were board certified; 80% had subspecialty training; and 89% provided direct patient care. Of the many topics reviewed, 56 showed disparity between preparation and importance scores. For 14 categories, mainly technical procedures, disparate ratings suggested excessive emphasis, while for 42

categories there may have been inadequate emphasis.

"As a group, basic skill and knowledge areas (eg, history taking, physical examination, and interpersonal skills) received the highest scores for importance," the researchers say. "In contrast, the ratings given to most technical procedures would suggest that their value declines with time. The declining value of many technical skills may reflect their short 'half life,' and may be an indication that some should be deemphasized in relation to other knowledge and skill areas."

The surveyed physicians had begun their residency programs at Boston University between 1973 and 1977 and were questioned in 1982.

"This study examines program content in the light of real-world demands made on practicing internists," the researchers say. "It indicates that, if internists are likely to practice primary care or general internal medicine, regardless of their subspecialty status, more emphasis on the basic skills required to practice general medicine is necessary." □

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## **Bane of travelers' existence becomes subject of NIH report**

As noted briefly in last month's JOURNAL, the National Institutes of Health (NIH) have released two consensus panel reports, "Health Implications of Obesity" and "Travelers' Diarrhea."

"Health Implications of Obesity" was compiled by a panel representing the professional fields of nutrition, nutritional biochemistry and metabolism, endocrinology, internal medicine, gastroenterology, epidemiology, biostatistics, psychiatry, pediatrics, and family medicine.

The panel formulated answers to the following questions: What is obesity? What is the evidence that obesity has adverse effects on health? What is the evidence that obesity affects longevity? What are the appropriate uses and limitations of existing height-weight tables? For what medical conditions can weight reduction be recommended?

Only these questions were addressed. Important issues relating to obesity such as prevention, treatment (including exercise), and the impact on society were not addressed, nor was the relationship of obe-

sity to lower socioeconomic status.

"Travelers' Diarrhea" looks at the most prevalent health problem of travelers to developing countries and at the continuing debate concerning whether the risk of antimicrobial prophylaxis is worth the benefit; whether early therapy of ill travelers is preferable to daily prophylaxis of all travelers; whether all currently employed treatment strategies are useful; and whether given groups of travelers, such as vacationers, students, or business travelers, should be selectively advised to follow special regimens.

The consensus panel that tackled these questions included epidemiologists, pediatricians, biostatisticians, microbiologists, internists, infectious diseases specialists, travel experts, and lay representatives.

Free, single copies of both statements are available from Michael J. Bernstein, Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 216, Bethesda, Maryland 20205. □

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## DEATHS

### **Forest Reed Brown, MD 1913 - 1985**

OSMA Life Member Forest R. Brown, MD, of Oklahoma City, died March 19, 1985. Dr Brown was born in Hanna, Okla, and attended the University of Oklahoma, where he earned his medical degree in 1936. His internship and residency were served in the Canal Zone in Panama. Upon his return to Oklahoma, he entered private practice in Mangum and Konowa. Three years later he went back to the Canal Zone and worked with the local health department until he again returned to Oklahoma in 1951. A specialist in preventive medicine and public health, he retired from the Oklahoma State Department of Health and the active practice of medicine in 1981.

### **Ernest S. Kerekes, MD 1916 - 1985**

Veteran Tulsa radiologist Ernest S. Kerekes, MD, died on June 8, 1985. A 1943 graduate of New York Medical College, Dr Kerekes was born in Passaic, NJ. He completed a residency in radiology at Louisville General Hospital, Ky, after serving as a captain in the US Army during World War II. Following teaching positions in Philadelphia and Little Rock, he entered practice in Tulsa in 1951. Dr Kerekes was a diplomate of the American Board of Radiology, a Fellow of the American College of Radiology, and a member of the Radiological Society of North America.

### **Robert Lewis Kendall, MD 1914 - 1985**

Robert L. Kendall, MD, a general practitioner, died in his home in Erick on June 21. He was born in Strong City, Okla, and graduated from the University of Oklahoma School of Medicine in 1940. From 1942 to 1946 he served with the US Army's 45th Division in North Africa, Sicily, Italy, Southern France, and Germany. After the war, he established a practice in Okmulgee, then moved to Erick in 1951. Prior to the war he practiced in Ardmore with the Veazey Clinic.

### **Marion K. Ledbetter, MD 1921 - 1985**

Marion Kenneth Ledbetter, MD, a 1946 graduate of the University of Oklahoma School of Medicine spec-

ializing in pediatric cardiology, died in Tulsa on July 3. Dr Ledbetter was professor and vice chairman of the Oral Roberts University School of Medicine, and also served as chief of pediatric cardiology at the City of Faith Medical Research Center. The Clarksville, Tex, native had practiced in Tulsa earlier in his career before moving on to positions in Wisconsin and Illinois. He returned to Tulsa in 1980, and earlier this year was honored as ORU's Outstanding Faculty Member.

## IN MEMORIAM

1984

<i>Ingvald John Haugen, MD</i>	<i>September 1</i>
<i>Hugh H. Monroe, MD</i>	<i>September 9</i>
<i>Martin H. Bartlett, MD</i>	<i>September 10</i>
<i>Seth D. Revere, MD</i>	<i>October 6</i>
<i>Oliver H. Patterson, MD</i>	<i>October 13</i>
<i>Emmett H. Lindley, MD</i>	<i>November 8</i>
<i>Clark H. Hall, MD</i>	<i>December 5</i>
<i>Henry G. Bennett, Jr, MD</i>	<i>December 18</i>
<i>Adoniram V. Bowen, MD</i>	<i>December 29</i>

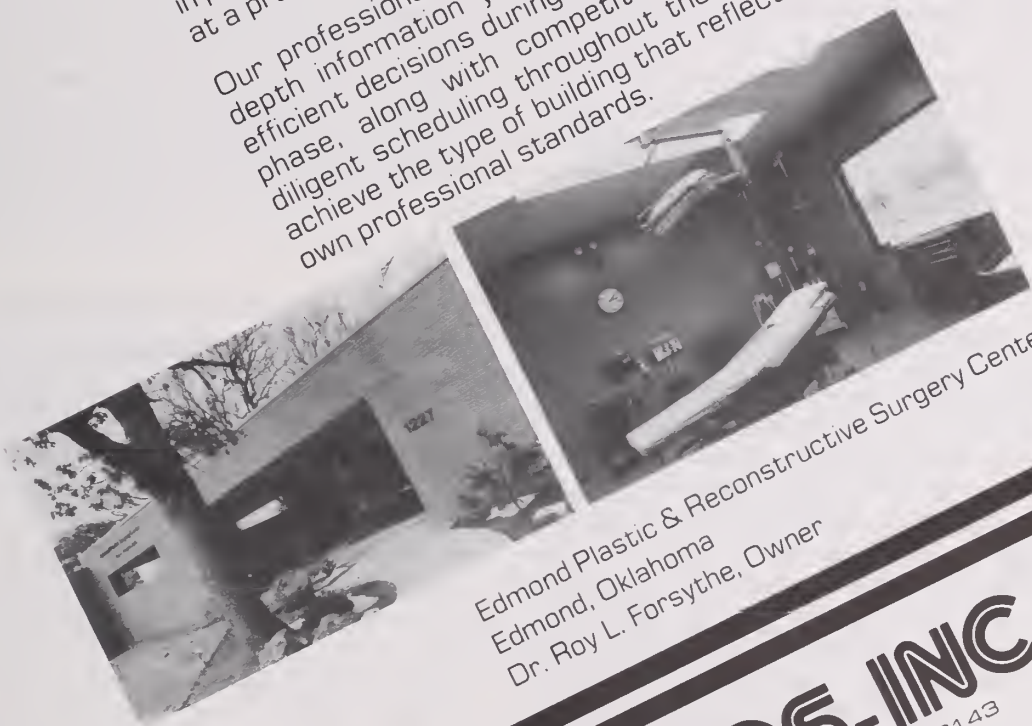
1985

<i>Owen L. Hill, MD</i>	<i>January 15</i>
<i>Earl M. Lusk, MD</i>	<i>January 30</i>
<i>Larry L. Lowery, MD</i>	<i>February 12</i>
<i>Harry Wilkins, MD</i>	<i>February 14</i>
<i>William H. Buchan, MD</i>	<i>February 15</i>
<i>Austin H. Bell, MD</i>	<i>February 23</i>
<i>Glen W. McDonald, MD</i>	<i>February 25</i>
<i>E.C. Lindley, MD</i>	<i>March 1</i>
<i>Charles W. Freeman, MD</i>	<i>March 5</i>
<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>Forest R. Brown, MD</i>	<i>March 19</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Hannah B. Karam, MD</i>	<i>March 28</i>
<i>Roy W. Donaghe, MD</i>	<i>May 1</i>
<i>L. Chester McHenry, MD</i>	<i>June 8</i>
<i>Ernest S. Kerekes, MD</i>	<i>June 8</i>
<i>Seigul J. Polk, MD</i>	<i>June 10</i>
<i>Murray M. Cash, MD</i>	<i>June 11</i>
<i>Franklin Jesse Nelson, MD</i>	<i>June 13</i>
<i>Robert L. Kendall, MD</i>	<i>June 21</i>
<i>Marion K. Ledbetter, MD</i>	<i>July 3</i>

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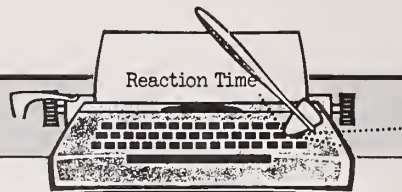
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## **"Sad Consensus" editorial still provoking reactions from MDs**

*To the editor:* This letter was dictated a while ago and the tape lost. I thought you might still like to know there is someone out there that listens.

I agree that it isn't quite fair to typify the medical profession as Dr Johnson has [JOURNAL, Nov 1984] and I also agree that his opinion is not widely held among our colleagues. I feel that Dr Johnson makes graphic points to show a lackadaisical medical profession that there are some serious problems that need some tough work. That Dr Johnson has to go to such great lengths to get the point across is indicative of the magnitude of the problem. Unless we realize that our iceberg is melting fast, we can't begin to build a steady ship to keep a viable profession. Colleagues who over-test, over-prescribe, over-charge, and seem to under-know and under-care put the heat on and keep melting us faster than we can build. Governments on all levels that do not understand the complexities of our profession are literally cooking our goose.

I can tell by Dr Groom's reply [JOURNAL, May 1985] that he is truly a physician and a healer (there is a difference) in that he obtains satisfaction from the social as well as from the intellectual challenges, but do you see how medical "advances" drive physician and patient further apart?

He mentioned those that are privileged to participate in the education of the next generation of physicians. I am also so privileged, but I see a great deterioration in the skills in our young physicians over the past seven years since I started my clinical rotations. The emphasis on the many medical specialties, malpractice threats to attendings, and loss of indigent patients to local doctors (welfare and Medicare patients used to be medical school patients), have all added to less hands-on training for the budding physician. Medical knowledge has expanded such that keeping up is impossible, but medical schools still try to "cram it all in all students" instead of facilitating the thought processes that would allow new physicians to utilize the tremendous potential of the full body of medical knowledge. In other words, students would use their hands and instruments to collect facts, then use their mind to sift through the relevant, then use computers to evaluate the possibilities, and then use their potential as caring human beings to participate in the partnership of healing of patient and doctor.

I would not paint such a gloom and doom picture, except that it seems that the medical profession is not able to organize to combat these problems, or even to communicate within its many arms. It is content to try to defense the status quo, all the while regressing into a corner.

The key to the future is physician involvement. Involvement in communication, involvement in major social problems such as unwanted pregnancy, involvement in cost controls, involvement in disciplining peers who stray from the straight and narrow, involvement in legislative and bureaucratic bodies, and most of all, involvement with individual patients as the physician serves them in the community.

*Robert C. Bowman, MD  
Nowata*

## **Cooperation and congratulation echo from AMA meeting**

*To OSMA President Elvin M. Amen, MD:* Thank you so much for your letter of July 3rd. I appreciate your offer of cooperation. Likewise I stand ready to help your delegation at the council level in any manner possible.

I was very happy to hear Perry Lambird won also. I know that he will be a very great asset to this council, and I look forward towards working with him.

Very warm regards to you and to members of your state organization.

*Mario E. Ramirez, MD  
Rio Grande City, Texas*

## **South Carolina doctor envies our status as unified state**

*To OSMA President Elvin M. Amen, MD:* Thank you for your note of July 3. I certainly appreciated the support of the Oklahoma delegation for my re-election to the AMA Council on Constitution and Bylaws.

I would like to congratulate all of the Oklahoma members on the fact that you are a Unified State. If you have any magic formula for achieving this status, please let me know. I certainly would like to push it in South Carolina.

*John C. Hawk, Jr., MD  
Charleston, SC*

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## Former dean sends letter of appreciation to OSMA friends

*To OSMA Executive Director David Bickham:* This letter is two-fold. First let me express my appreciation to you and through you to the Oklahoma State Medical Association my appreciation of the privilege to have been a member of this outstanding organization for the past five years. I appreciate the personal support and expressions of concern during our times of ill health and the professional support of the College of Medicine that has been a constant. I think there has never been a time in medical history when it is more important that there be continued close communication between medical education and organized medicine and I am certain that you and the association will continue to make it possible for the Office of the Dean to have that kind of communication with the society and its delegates.

Secondly, let me notify you of my new address

and my desire to transfer my membership from the Oklahoma State Medical Association to the Texas Medical Association. I have made a similar communication to Linc Williston, the Executive Director of the Texas Medical Association. Effective June 27, 1985, my new residence address will be The Anderson Mayfair, Apt. 909, 1600 Holcombe Blvd., Houston, Texas 77030; my new office address will be Vice President for Patient Affairs, The University of Texas System Cancer Center, M.D. Anderson Hospital and Tumor Institute, 6723 Bertner Ave., Houston, Texas 77030.

Thank you for your assistance in this matter and for the privilege of the past association.

Charles B. McCall, MD  
Houston

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## BOOK REVIEWS

### **New Perspectives on Calcium Antagonists.**

Edited by George B. Weiss. Baltimore: American Physiological Society, 1981. Pp 241, price not given.

The concept that organic compounds can competitively interfere with the action of inorganic calcium has given a new orientation to cardiovascular research and therapy. *New Perspectives on Calcium Antagonists*, edited by George B. Weiss of the University of Texas Health Sciences Center in Dallas, is a scholarly contribution of the Clinical Physiological Series from the American Physiological Society.

This book is composed of eighteen chapters written by individuals who are actively involved in this area of investigation. Although it was published in 1981, it does contain state-of-the-art information concerning calcium mechanisms involved in cardiovascular function and certain endocrinologic activity. The information is concise, clearly presented, and should be of definite value to educators who desire foundational information on calcium channel mechanisms and the effects of its pharmacologic antagonism.

Chapters One through Five describe the nature of calcium channels, subcellular calcium mechanisms, and where and how calcium antagonists act. Chapters Six through Ten focus on the effects of the different calcium antagonists on various types of vas-

cular smooth muscle. A most informative presentation by Dr Paul Vanhoutte, a renowned vascular researcher, presents comparative effects of calcium antagonism on various organ vascular beds. Curiously, the canine gastrosplenic vein and basilar artery were at the high end of the sensitivity spectrum, while the tibial and coronary arteries occupied the lower end. Information is also presented on flunarizine, a new calcium channel blocker that likely will be marketed soon.

While this collection of basic information on calcium channels and their pharmacologic antagonism should continue to be meaningful, it does not deal with therapeutic matters. As a resource it should be kept in mind, and spending thirty minutes to an hour looking at some of the figures and reading the legends should be most helpful in building a firm foundation regarding calcium channel mechanisms.

Thomas L. Whitsett, MD  
Oklahoma City

### **Medical Office Design: Territory and Conflict.**

By Henry P. Doble, Jr., PhD. Saint Louis: Warren H. Green, Inc., Pp 188 with 78 illustrations, price not given.

Dr Doble is an expert in medical office design and



management who offers the physician, whether in solo or group practice, many practical suggestions for analyzing and solving problems in office practice.

Using many case study examples and numerous illustrations, the book addresses common practice problems relating to space utilization and scheduling of time.

This book will be most useful to practicing physicians who are not pleased with the way their practices are functioning. However, it may be advisable for some practitioners to hire a consultant before spending the large sums of money that might be necessary to follow some of the suggestions in this book.

Young physicians completing training may find this book interesting, and it could help them avoid many of the pitfalls described. However, an additional section or a separate book on establishing a new office might be of more value to them.

*Hal B. Vorse, MD  
Oklahoma City*

**Radiology of the Colon: Golden's Diagnostic Radiology.** Edited by Jack R. Dreyfuss, MD, and Murray L. Janower, MD. Baltimore: The Williams and Wilkins Company, 1980. Pp 583, price not given.

This publication replaces *Radiologic Examination of the Colon* from the Williams and Wilkins Company in 1969. It is a compilation of collaborators from among past and present colleagues of the Massachusetts General Hospital. It is very well written and well edited so as not to be repetitious. The illustrations and radiographic reproductions are excellent. There are twenty chapters covering the entire spectrum of history, techniques of examination, and radiographic pathology of the colon. The chapter on polyps is particularly well written and makes the analysis of controversial statistical data convincing. This book can serve as both a textbook and a quick reference for radiologists, surgeons, internists, and family medicine practitioners.

*Bob G. Eaton, MD  
Oklahoma City*

**Hepatotropic Factors.** Ciba Foundation Symposium 55 (new series). Amsterdam, Oxford, and New York: Elsevier / Excerpta Medica / North-Holland, 1978. Pp 405, \$36.00.

This monograph contains the papers and discussions of the above symposium held in London, May 1977. Most are concerned with structural dynamics

of liver regeneration and consideration of insulin and glucagon physiology. Also discussed are the factors that potentially stimulate growth of hepatic tissue. The last group of papers deals with aspects of fulminating hepatic failure, storage disease, and diabetes mellitus.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Peptide Transport and Hydrolysis.** Ciba Foundation Symposium 50. Amsterdam, Oxford, and New York: Elsevier / Excerpta Medica / North-Holland, 1977. Pp 385, price not given.

This monograph contains seventeen papers and discussion originally presented at the conference by the same name held in November 1976 in London. The conference concentrated on peptide transport and peptidases in relation to intestinal functions, various forms of celiac disease, and the Fanconi syndrome.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Iron Metabolism.** Ciba Foundation Symposium 51. Amsterdam, Oxford, and New York: Elsevier / Excerpta Medica / North-Holland, 1977. Pp 391, \$32.25.

This monograph contains sixteen papers and their discussion from a meeting held in December 1976 in London. Attention was focused on ferritin and transferrin, and problems induced by iron overload.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Contemporary Standards for Antimicrobial Usage.** William R. McCabe and Maxwell Finland, editors. (Principles and Techniques of Human Research and Therapeutics, F. Gilbert McMahon, editor). Mt Kisco, NY: Futura Publishing Co., 1977. Pp 187, price \$13.50.

This volume contains the proceedings of the meeting on principles and techniques of human research held in New Orleans. The overall purpose of the meeting was to address the important but controversial issue of developing reasonable standards for antimicrobial use in humans.

The introductory remarks of Dr Maxwell Finland are meaningful and lead into the many-sided problem of enormous overuse of anti-infective agents in the United States. It was generally agreed that a consen-

sus must be arrived at on the subject of appropriate antibiotic use in private practice and, when this is accomplished, education of physicians to these new principles must be accomplished.

The first few topics concern the pros and cons of devising rigid standards. The complex solution lies in conducting specific clinical trials set up to delineate clinical guidelines.

The second major portion of the monograph deals with considerations of standards in clinical practice. Is it possible to develop standards for the use of antibiotics in some of the more readily diagnosed infections, such as pharyngitis and otitis media? This probably can be done when the correct etiology is recognized fairly quickly. However, in diseases in which the diagnosis is more difficult, such as pneumonia, the problem may be too complex for standards to dictate the correct therapy. Some of the problems encountered in attempting to devise standards are

illustrated by discussions on the use of antibacterial therapy in pneumonia, in urinary tract infections, in acute infectious diarrheal disease, in intra-abdominal sepsis and anaerobic infections, and in acute endocarditis. Leon Sabath, in his chapter on febrile patients without an established diagnosis, shows how guidelines become too complex even in preliminary evaluation.

In his summary, McCabe brings into focus the pressures felt by the physician as he treats infectious diseases in the confusing environment of both individual and group concerns.

This small monograph contains much of interest for the practicing physician and for those teaching prospective physicians about the proper use of antimicrobial therapy.

*Harris D. Riley, Jr., MD  
Oklahoma City*

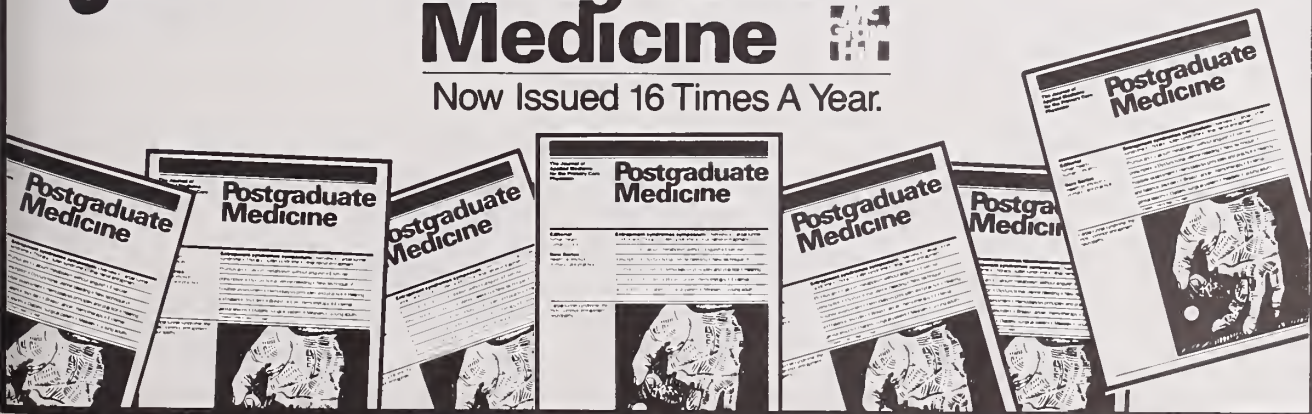
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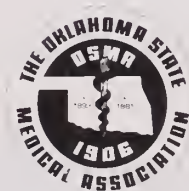
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November 8 Friday	Law for the Medical Office (afternoon)	Tulsa Sheraton Inn Skyline
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February 1 Saturday	Gearing Up For Retirement (Tentative)	Oklahoma City



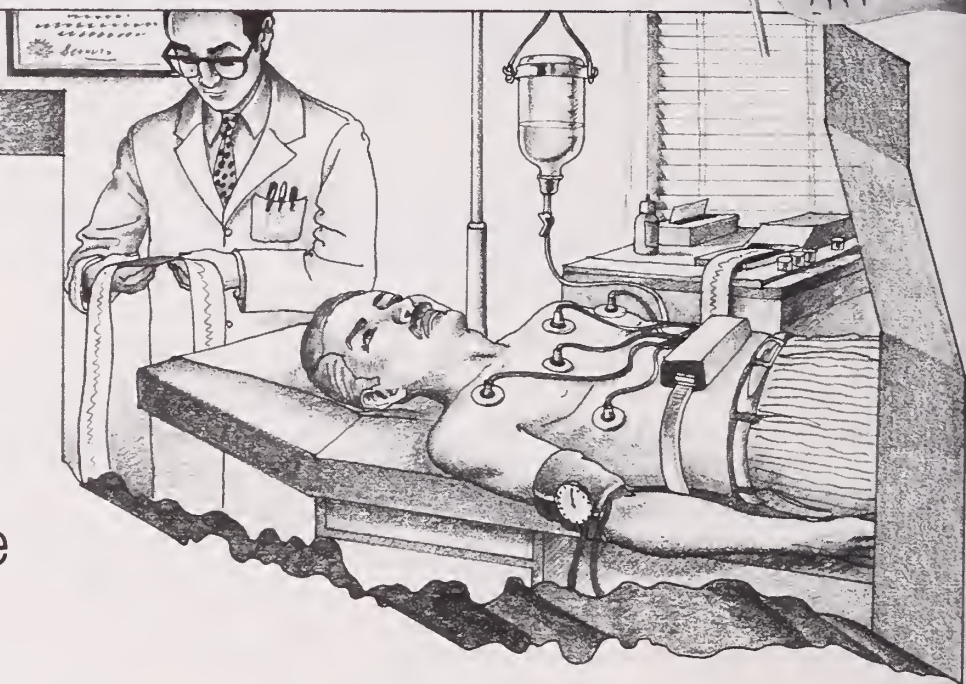
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Investigational studies were undertaken on the basis of the physiologic response to intravenous epinephrine infusion in patients with chest pains. Arterial blood pressure, systolic time intervals and ECG measurements were recorded before, during and after the infusion.

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While the patient sample was statistically small, the results were significant. The predictive value of a positive test for coronary disease was 100%, while the predictive value of a negative test for excluding coronary disease was 80%.<sup>2</sup>

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**References:** 1. Treadmill test alternative. *Diagnosis*, Jul 1983, p 11.  
2. Schechter E, Wilson MF, Kang Y-S. *Am Heart J* 105:554-560, Apr 1983.

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\*Feighner JP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979

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**Warnings:** Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Libitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

**Precautions:** Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Libitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

**Adverse Reactions:** Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Libitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Libitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

**Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

**Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

**Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extropyrpyramidal symptoms, syncope, changes in EEG patterns.

**Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

**Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

**Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

**Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

**Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

**Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Overdosage:** Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

**Dosage:** Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Libitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Libitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

**How Supplied:** Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.



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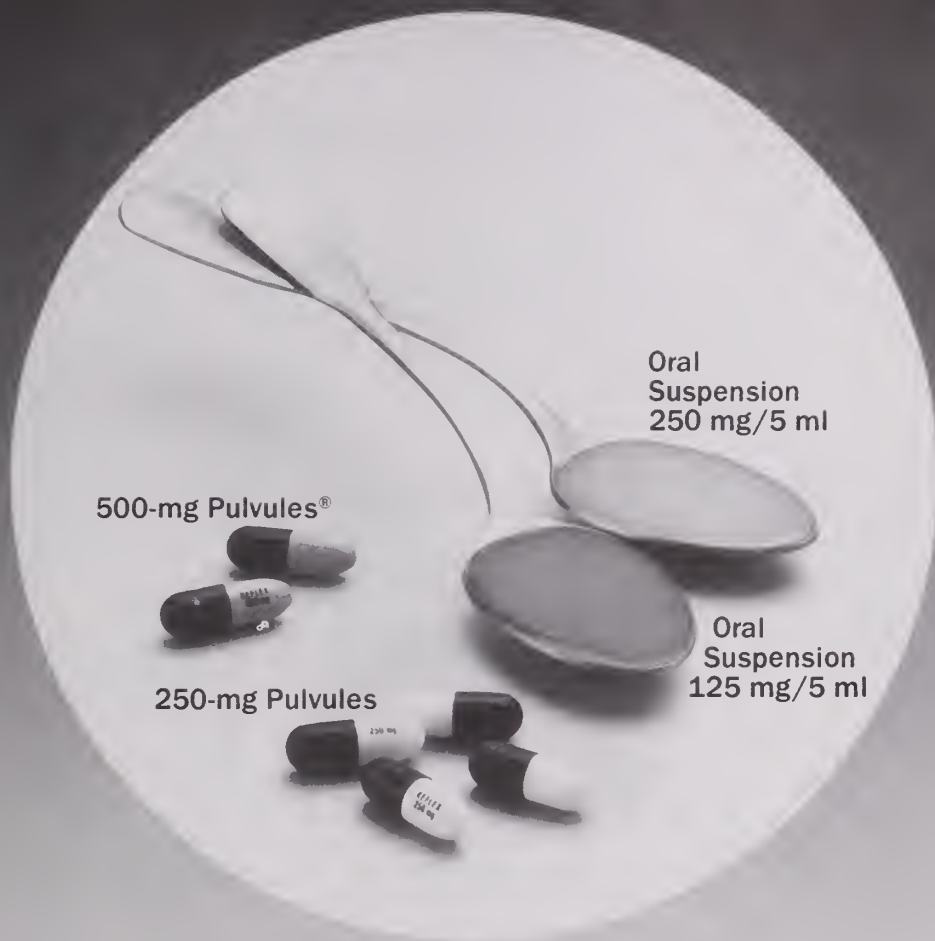
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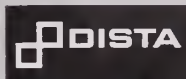
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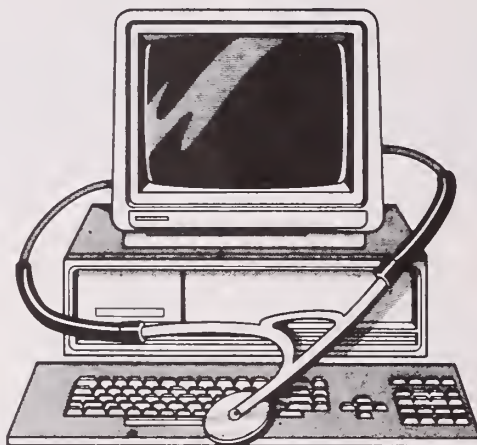
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with a low  
incidence of  
side effects

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CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

\*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

### References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. *Am J Cardiol* 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. *Chest* 78 (July suppl):234-238, 1980.

## **Reduces angina attack frequency\***

42% to 46% decrease reported in multicenter study.<sup>1</sup>

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In Bruce exercise test,<sup>2</sup> control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ( $P < .005$ ).

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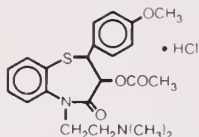


## PROFESSIONAL USE INFORMATION



### DESCRIPTION

**CARDIZEM**® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)-one, 3-(acetoxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-[4-(methoxyphenyl)]-, monohydrochloride, (+)-cis-. The chemical structure is



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

### CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

**Mechanisms of Action.** Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. **Angina Due to Coronary Artery Spasm:** CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. **Exertional Angina:** CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

**Hemodynamic and Electrophysiologic Effects.** Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length up to 50% in some cases.

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

**Pharmacokinetics and Metabolism.** Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

### INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).

2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance. There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

### WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

### PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

**Pediatric Use.** Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%),

headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence:

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other:	Polyuria, nocturia

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

### OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD<sub>50</sub>'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD<sub>50</sub>'s in these species were 60 and 38 mg/kg, respectively. The oral LD<sub>50</sub> in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

### DOOSAGE AND ADMINISTRATION

**Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm.** Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

#### Concomitant Use With Other Antianginal Agents:

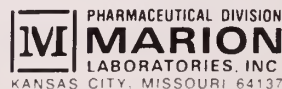
1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

### HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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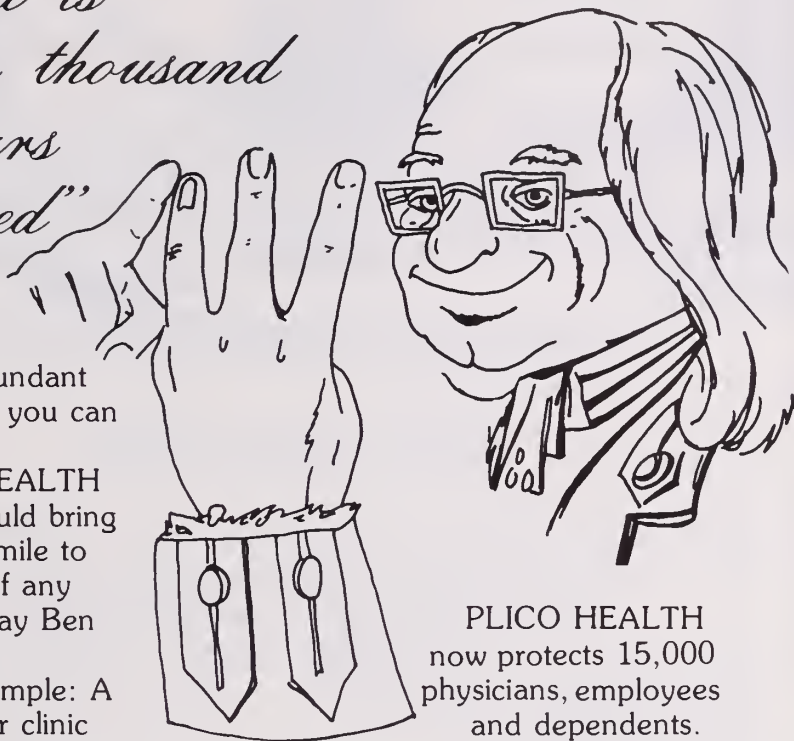
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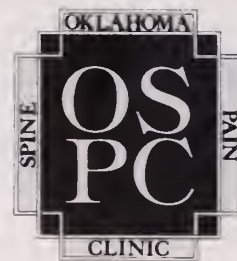
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For Doctors Only .....	26A
C. L. Frates & Co., Inc. ....	353
Glass-Nelson Clinic .....	22A
Harsha Orthopedic, Inc. ....	26A
Marion Laboratories ( <i>Cardizem</i> ) .....	15A, 16A
McAlester Clinic .....	22A
Medical Arts Clinic of Ardmore .....	23A
Medical Arts Laboratory .....	25A
James B. Morris II & Associates .....	12A
Oakdale Farm .....	7A
Oklahoma Allergy Clinic .....	20A
Oklahoma City Clinic .....	IFC
Oklahoma Hand Surgery Center, Inc. ....	25A
Oklahoma Lung Function Laboratory .....	25A
Oklahoma Plastic and Reconstructive Surgeons, Inc. ....	26A
Oklahoma Urology Center .....	26A
Orthopedic & Arthritis Center .....	23A
Orthopedic Associates .....	24A
OSMA Council on Member Services .....	9A
PLICO .....	17A
<i>Postgraduate Medicine</i> .....	361
Professional Billing Associates .....	355
Rehabilitation Institute of Oklahoma .....	354
Roche Products, Inc. ( <i>Limbitrol</i> , <i>Dalmane</i> ) .....	10A-12A, IBC, BC
Shawnee Medical Center Clinic, Inc. ....	21A
Southern Plains Medical Center, Inc. ....	21A
Timberlawn Psychiatric Hospital .....	20A
Tulsa Adjustment Bureau, Inc. ....	348
The Upjohn Company ( <i>Motrin 800</i> ) .....	5A
Waldrop Bros., Inc. ....	357
Willow View Hospital .....	18A

# JOURNAL

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### Style

All manuscripts should adhere to the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual for Authors & Editors*. Footnotes, bibliographies, and legends for illustrations should be typewritten, double-spaced, on separate sheets. References are to be listed in the order of their appearance in the article.

### Illustrations

Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations should be labeled with the author's name and must be numbered in the order in which they are referred to in the article. The quality of all illustrations must be in keeping with the quality of the magazine.

### News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc., are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

### Reprints

Authors will receive reprint order forms from the Transcript Press, 222 East Eufaula, Norman, Oklahoma 73069, prior to publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

### Back Issues

Microfilm copies of back issues of the JOURNAL can be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

## Come Blow Your Horn!

In reflecting on the year ahead, my year as president-elect of the Oklahoma State Medical Association Auxiliary was a time of anticipation. What did I want the auxiliary to accomplish during my time as president? One of the goals I set for myself was to try to assist in getting new members in our organization. I wanted to see the image of our physician spouses improved, and, for that matter, our own image improved. A sure way to accomplish that was to beef up our health projects, to be visible in the communities as the medical auxiliary. So I invited the auxiliary to "Come Blow Your Horn!"

In my inaugural address on May 6, I pleaded a case — "Your physician is your best friend." I stated that the auxiliary has a real challenge facing us at this time and that challenge can blossom into an opportunity. Some of the challenges and opportunities facing us, I said, were the following:

- We have the opportunity to tell the person who is thankful for good health that his health is better than ever. We have the challenge to participate in the AMA's effort to help find ways to cut the cost of delivering health care;
- We have the task of determining what we can do to inform the public that their physicians are their best friends, and that they are the losers in most malpractice cases;
- We have the privilege of extending our physicians' concern to the elderly by being emissaries as spouses;
- We have the best of resources from our national organization to lay in the hands of the public regarding health care; and
- We face the challenge of increasing our membership not just to increase, but to bolster our man and woman power to accomplish these goals.

In recent AMA newsletters there were statistics on what the public feels about our spouses. Their image continues to decline in socioeconomic areas, especially fees and income. "The doctors are too in-

terested in making money," 67% of them felt in 1984, as opposed to 60% in 1982. In discussing physicians' fees, in 1984 27% felt they were reasonable, as compared to 42% in 1982. Forty-four percent felt that physicians explained things well in 1984, compared to 55% in 1982. Concerning the AMA fee freeze, even though seven out of ten physicians agreed to voluntarily freeze their fees, only 32% of the public believed they would comply. Only 32% felt that physicians' fees in general were reasonable. Yet in both cases, the public were less skeptical about their own personal physicians!

The auxiliary has plans to put ourselves and our physician spouses before the public more than ever. We plan to implement the distribution of the MEDIFILE, a wallet-size prescription card for aging Americans' use. These will be in the doctors' offices and will be given to the patients only by the doctor or his or her employee. They will be compliments of the OSMA and the OSMAA.

We plan to have a Media Day. Participating auxiliaries will set aside an event in which they will honor members of the media. It is the auxiliary's feeling that, more than ever, the media must be our allies. What better way can we accomplish this than by meeting with them personally?

We plan several health projects besides the MEDIFILE. There are public service announcements aimed at senior citizens, telling them, "Don't retire from life!" We will focus on prenatal and postnatal care at our fall confluence. And, as usual, each county auxiliary will serve its own community in a personal way.

It is the hope of the Oklahoma State Medical Association Auxiliary that we can improve the image of our physicians and that in some way this will help to make the public our allies in future times. If we don't blow our horns, no one will!

— Mary Ann Deen



## THE LAST WORD

■ **OSMA Deputy Executive Director Rick Ernest** has announced that he will be leaving the OSMA this month to become executive director of the Oklahoma County Medical Society. Formerly director of personnel at Norman Municipal Hospital, Ernest has been with the OSMA since 1977. During that time he has been actively involved with OSMA's councils on Medical Education, Medical Services, and Hospital Medical Staffs.

■ **The Oklahoma Academy of Family Physicians** has named Kenneth Whittington, MD, Bethany, as its candidate for the American Academy of Family Physicians (AAFP) Board of Directors. The election will be held during the AAFP's Congress of Delegates in Anaheim, Calif, in October. Dr Whittington is a past president of the Oklahoma Academy and has also represented Oklahoma as a delegate and alternate delegate to the AAFP Congress.

■ **Tulsa family physician John Keown, MD,** received the 1985 Outstanding Family Physician of the Year award at the Annual Scientific Assembly of the Oklahoma Academy of Family Physicians in Oklahoma City this spring.

■ **The University of Oklahoma College of Medicine** graduated 173 new physicians at its June 2 commencement ceremonies. Ninety-eight of them are remaining in the state for their internships and residencies. Thirty-seven of the graduates studied at OU's Tulsa Medical College, and 136 were from the Oklahoma City campus. Presiding at the commencement was Dean Charles McCall, now at his new post as vice president for patient affairs at M.D. Anderson Hospital and Tumor Institute in Houston.

■ **Different commercial lab tests can give statistically different test results on the same specimen,** according to a study appearing in the August *Archives of Pathology and Laboratory Medicine*. Benjamin Gerson, MD, of Harvard Medical School, and Mary Ann Figoni, MT (ASCP), of New England Deaconess Hospital, tested quantitation of glucose in human serum, plasma, or whole blood. Compared were products of Beckman Instruments, Eastman Kodak, Seralyzer System, and Dextrostix strips of Ames Co. Statistically significant and medically important differences were noted, suggesting that results can not necessarily be used interchangeably.

■ **The Third Annual Chronically Ill and Aging Conference** will be held November 21-23, 1985, in Oklahoma City. CME credits will be awarded for attendance. For information on the conference, contact: Dr John A. Mohr (111), VAMC, 921 NE 13th Street, Oklahoma City, Oklahoma 73104, phone (405) 270-5149.

■ **Three OSMA members have received 1985 Aesculapian Awards for Outstanding Teaching** at the University of Oklahoma College of Medicine. In Oklahoma City, Jerry B. Vannatta, MD, Department of Medicine, was given the clinical sciences award. In Tulsa, Daniel C. Plunkett, MD, and James W. Wheelless, MD, of the Department of Pediatrics received the clinical sciences and housestaff awards, respectively.

■ **Members of the OSMA now have exclusive access to the AMA Membership Ombudsman,** Wende L. Corbett, by virtue of the OSMA's status as a unified medical society. This position was mandated by the AMA House of Delegates at its 1984 Interim Meeting as a special benefit to members from unified societies. Ms Corbett will personally handle inquiries, requests, and complaints as well as coordinate services with other AMA areas in order to provide unified members with exclusive and unique access to AMA services. Call collect using the unified member hotline (312) 645-5323.

■ **Two Oklahoma City physicians received awards from the Alumni Association of the University of Oklahoma College of Medicine** at its annual meeting in May. Ronald C. Elkins, MD, chief of thoracic surgery at the Health Sciences Center, was named Academic Physician of the Year and neurologist Don F. Rhinehart, MD, was named Physician of the Year.

■ **Decision analysis may be preferable to second opinions in verifying surgical decisions,** asserts John R. Clarke, MD, of the Medical College of Pennsylvania in Philadelphia, writing in the July *Archives of Surgery*. Decision analysis is a mathematical process by which a decision maker can represent and solve decision problems. In a study, it was compared with second opinions to solve hypothetical surgical problems, and was found to be more than 10% more accurate, Clarke says.

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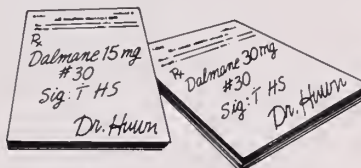
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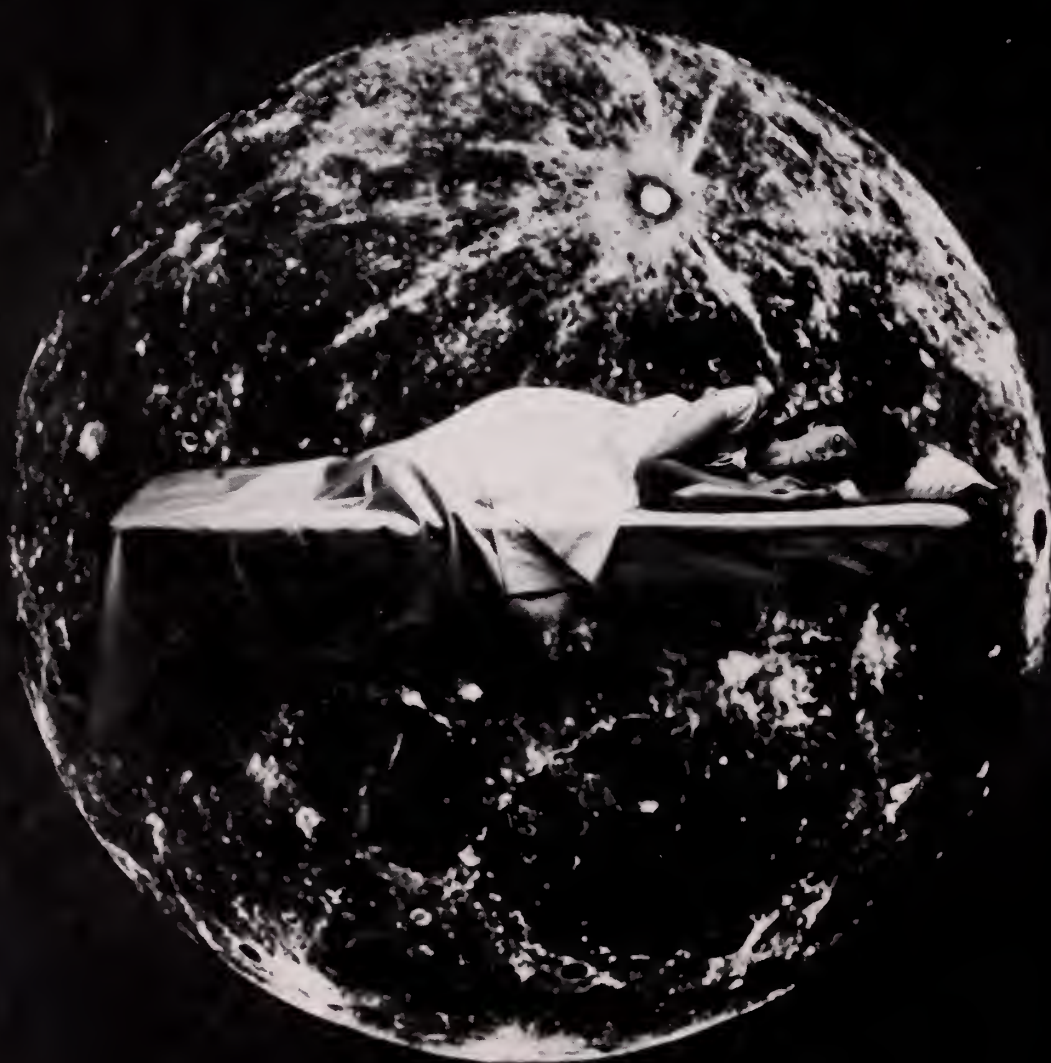


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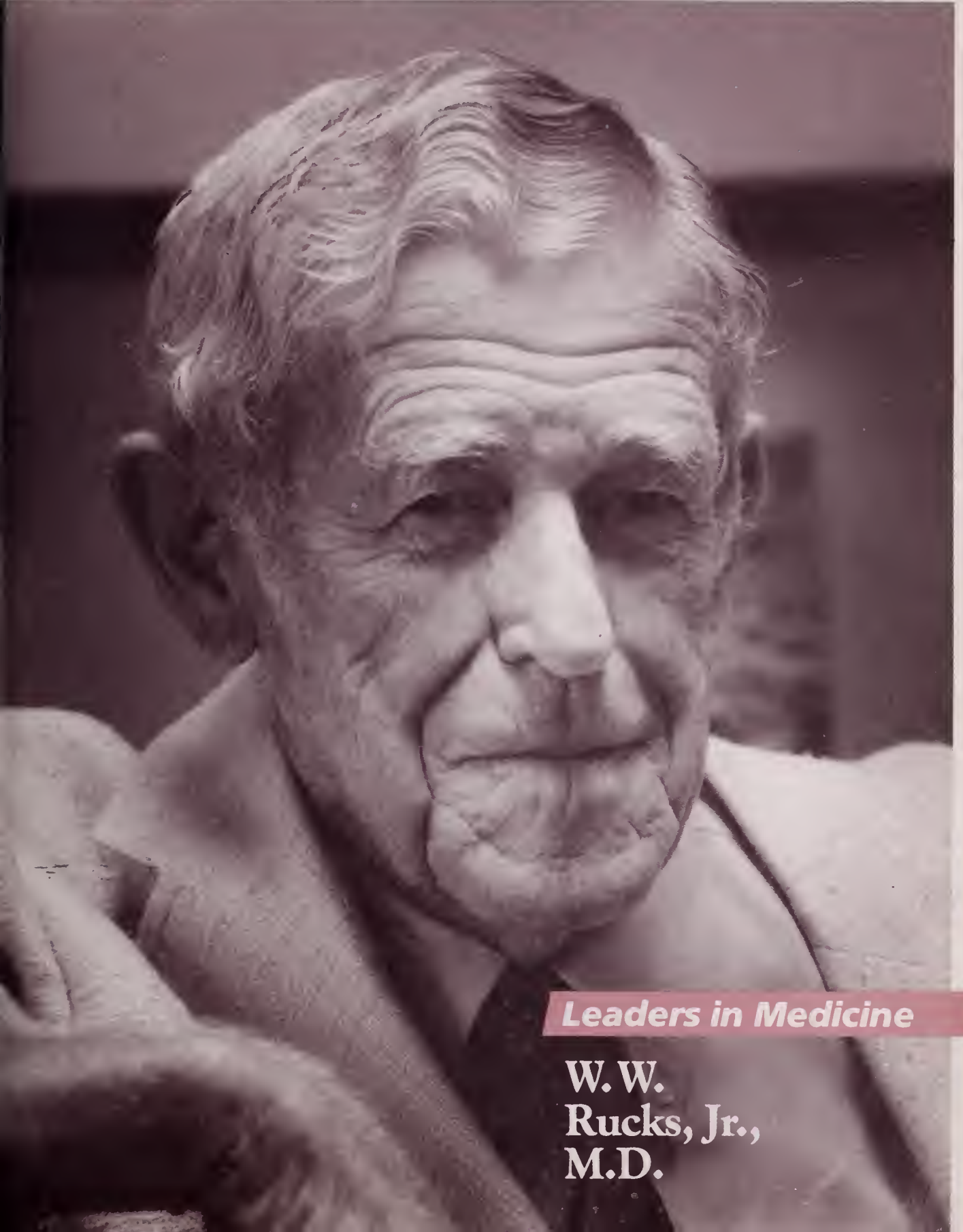
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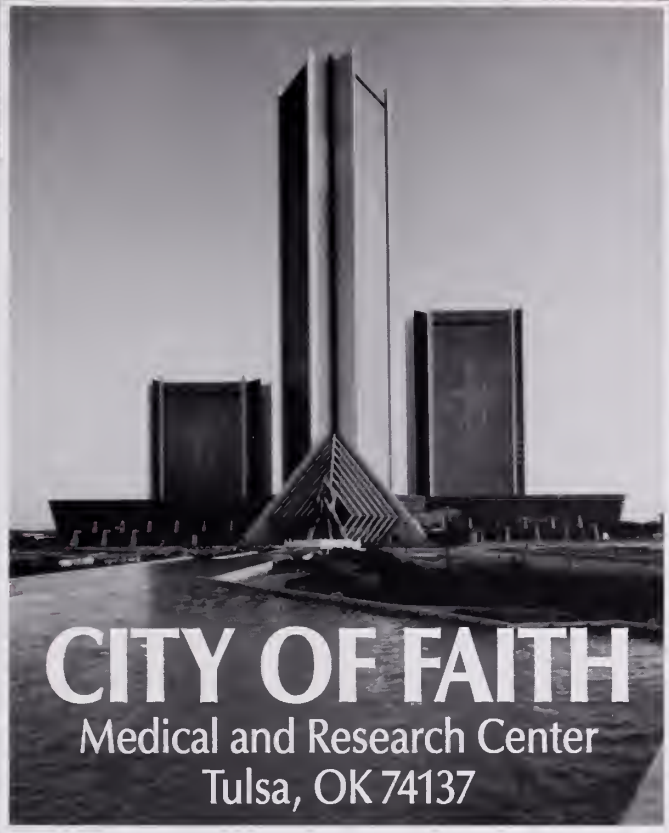
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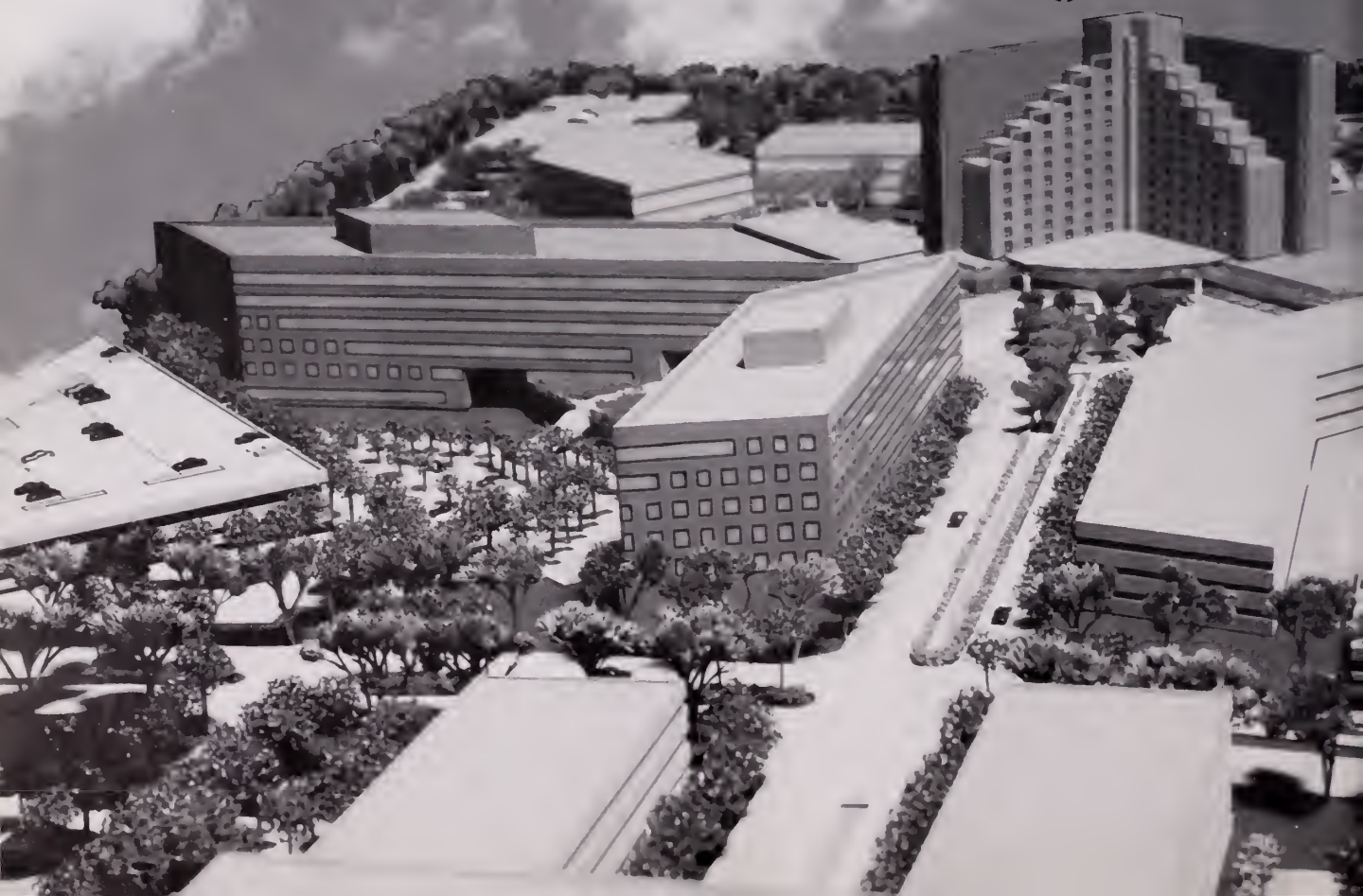


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# JOURNAL

## Oklahoma State Medical Association

OCTOBER 1985

VOL. 78, No. 10

#### EDITORIAL

- Let's Give Ourselves This Year ..... 363  
MARK R. JOHNSON, MD

- President's Page ..... 364  
ELVIN M. AMEN, MD

#### SPECIAL

- Leaders in Medicine: William W. Rucks, Jr., MD .... 365  
RICHARD GREEN

#### SCIENTIFIC

- Hypertension I: The Relationship of Hypertension to  
Serum Cholesterol, Triglycerides, and Sodium ..... 375  
ASEGASH TSEGAYE, PhD; CHARLES R. RITCHEY, MD;  
ROBERT D. MORRISON, PhD

- A Chronic Illness and Geriatric Assessment,  
Evaluation, and Rehabilitation Unit ..... 380  
JOHN A. MOHR, MD, and HUGH L. LONG

#### SPECIAL

- A Study of 138 Return Service Scholarship Applications . 384  
JUNE E. HOLMES, EdD, and DEBORAH A. MILLER, MS

#### NEWS ..... 391

MAPS to help select practice sites . . . Study examines suc-  
cess of female physicians . . . Hair analysis unreliable for  
diagnoses . . . Student picnic in OKC draws crowd . . . FDA  
may approve irradiation of food . . . NIH looks at dentists'  
use of general anesthesia . . . Childhood obesity offers clue  
to atherosclerosis . . . Tendency to depression inherited? . . .  
Mitsubishi to test AMA/NET in Japan . . . DRG monitoring  
continues

#### DEPARTMENTS

- |                        |     |                     |     |
|------------------------|-----|---------------------|-----|
| State Department       |     | Index to            |     |
| of Health .....        | 389 | Advertisers .....   | 32A |
| Deaths .....           | 403 | Instructions for    |     |
| In Memoriam .....      | 403 | Authors .....       | 32A |
| Book Reviews .....     | 404 | Auxiliary .....     | 33A |
| Miscellaneous Adv. ... | 406 | The Last Word ..... | 34A |

On the cover:

William W. Rucks, Jr., MD  
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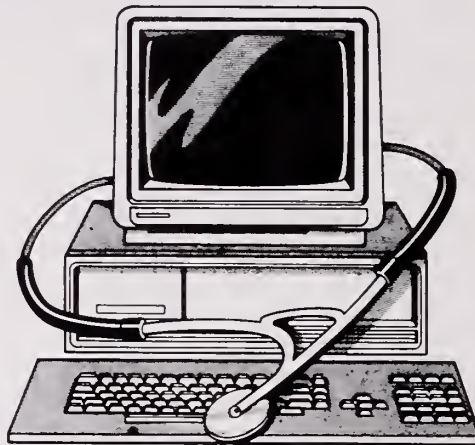
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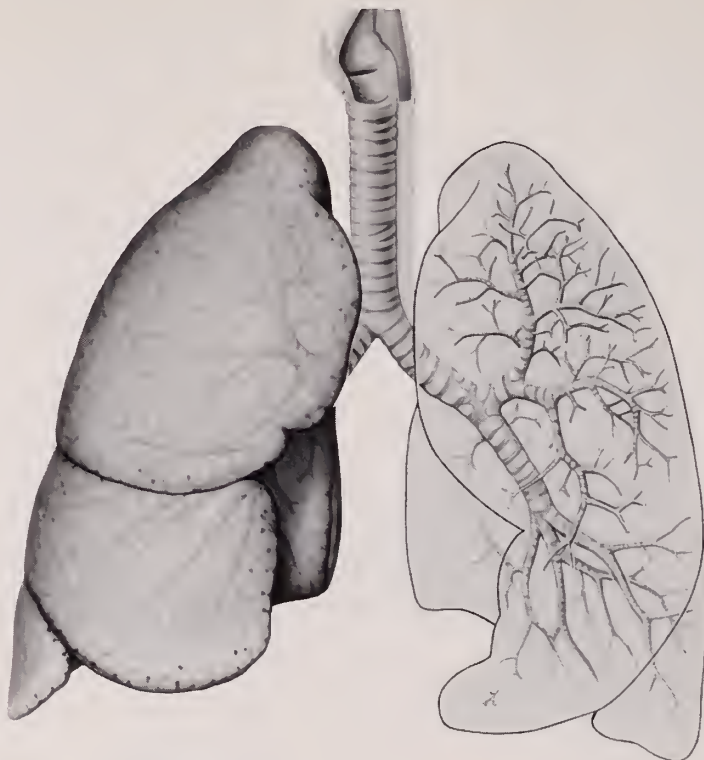
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**Brief Summary** Consult the package literature for prescribing information.

**Indications and Usage** Cecilor<sup>®</sup> (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

**Lower respiratory infections**, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cecilor.

**Contraindication** Cecilor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics including Cecilor should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics including macrolides, semisynthetic penicillins, and cephalosporins; therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, manage-

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

**Precautions: General Precautions**—If an allergic reaction to Cecilor<sup>®</sup> (cefactor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids. Prolonged use of Cecilor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cecilor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cecilor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinette<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

**Usage in Pregnancy**—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cecilor<sup>®</sup> (cefactor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers**—Small amounts of Cecilor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Cecilor is administered to a nursing woman.

**Usage in Children**—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

**Adverse Reactions** Adverse effects considered related to therapy with Cecilor are uncommon and are listed below.

**Gastrointestinal symptoms** occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

**Hypersensitivity reactions** have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported.

These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain**—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic**—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic**—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal**—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

**Note** Cecilor<sup>®</sup> (cefactor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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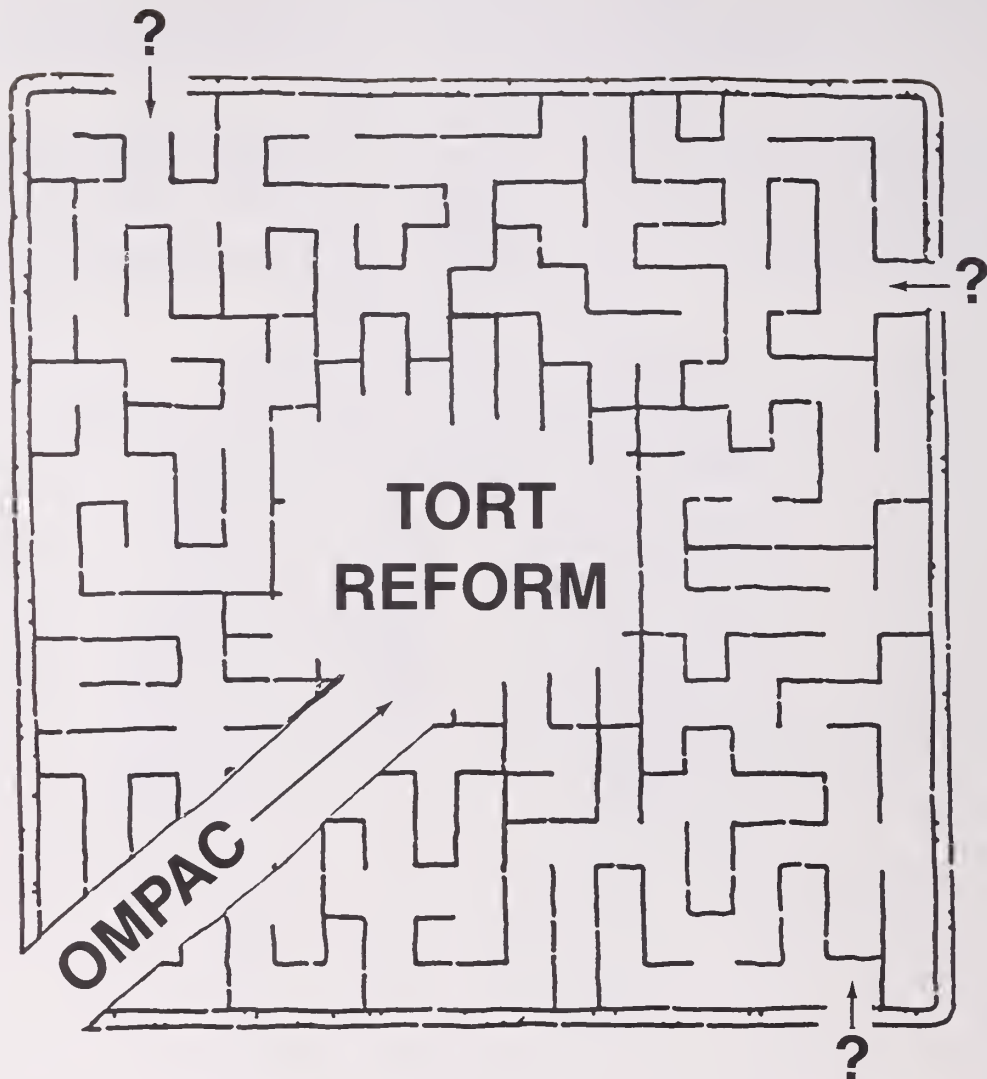
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## Let's Give Ourselves This Year

Occasionally someone asks me why we can't send copies of the JOURNAL to the administrators of the hospitals in the state, or to the presidents of the other professional associations in the state, or to the editors of the state's newspapers, or to a variety of others who have an interest in the affairs of the Oklahoma State Medical Association. My answer is always the same, always drawn out, always apologetic, and probably always misunderstood. Maybe it's only because no one wants to listen to a recitation of the postal regulations which prevent us from exercising the suggested generosity. It isn't that we couldn't send copies to all the suggested recipients; it's just that we would have to pay the "regular rates" and the cost of doing that would be prohibitive.

As cited in Paragraph 426.11, Issue 13, 12-29-83 of the Domestic Mail Manual

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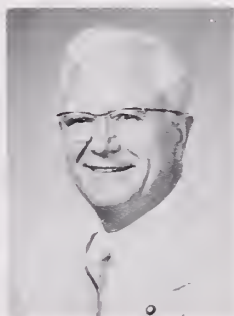
—MRJ



**T**he credibility of the medical profession needs to be fortified at all levels of contact with the "outer world."

One area of urgent need is to establish good rapport with the legislative branch of our government. Every one of us needs to maintain and improve our communications with our state and national elected officials.

One method of establishing a basis for communications is in the campaign and election process.



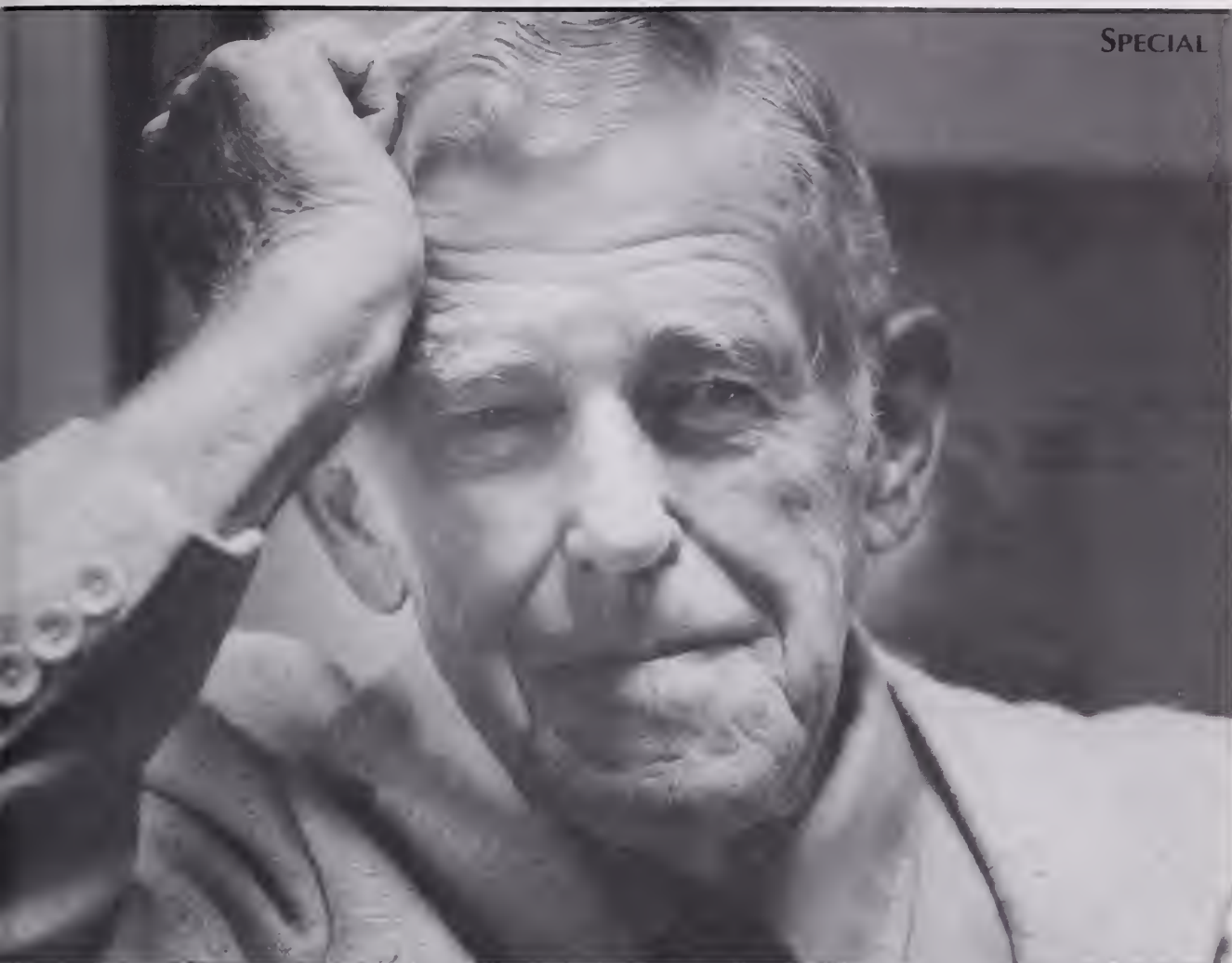
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Sincerely,

*Elvin M. Amen, M.D.*



*Leaders in Medicine*

## ***William W. Rucks, Jr., MD***

*Story by RICHARD GREEN  
Photographs by J. DON COOK*

**E**ven in 1920, the Webb School was an anachronism. Yet after the first few days of his junior year, all Bill Rucks knew was that it sure was tough and that academically he was far behind his classmates who, unlike him, were beginning their third year there.

"There" was in Bell Buckle, Tennessee, where the

school's founder, W. R. "Sawney" Webb, had moved it in 1886. When Bill arrived in 1920, old man Webb was still running the place with the assistance of his son, a chip off the old block called "Son Will" Webb.

Though Webb was a college preparatory school, the Webbs' main goal was to develop leaders, so they taught moral values and emphasized character-build-



ing traits: honesty, pride in work well done, decency in conduct, and a sense of responsibility.

It was the methods used to achieve this laudable objective that made the school anachronistic. The rules were arbitrary and often bizarre (no stopping on paths between buildings during school hours) but were rigidly and fairly enforced. The curriculum was strictly classical; it would have been familiar to Julius Caesar.

For a reason he still doesn't know, now sixty-five years later, Rucks took an immediate liking to the place and soon "was desperate to stay there." Perhaps he intuitively knew what was good for him, for he says that Webb School "was probably the best thing that ever happened to me. It was the turning point in my life."

Those monastic two years stressing rigid discipline, clear thinking, and academic achievement certainly prepared him for college, but that was only the initial payoff. Rucks also was well equipped to cope with the rigors that lay beyond — in his development as a physician and during World War II on those bloody Pacific islands from the Solomons to the Philippines.

**T**his is not to say that William Ward Rucks, Jr., was a tabula rasa before 1920. He'd been born in Guthrie in 1904, three years before statehood. His father, the original William Ward Rucks, was a general practitioner there and in Logan County. His mother was an English teacher. To Bill and his younger brother, Joseph, who also went to Webb School, they were obvious examples of the value of a good education.



Bill was a good student who liked school and loved to read. He occasionally accompanied his father on house calls and admired the way he treated his patients. Yet Bill apparently never made a conscious decision to become a physician himself — not in the sense that his father had.

As the story goes, when Bill's father was a child, he saw the town doctor riding in a new buggy and somehow the vocation and the transportation became linked in his mind. You had to be one in order to get the other.

In about 1910, the family moved to Fort Supply, where Dr Rucks served as superintendent of the state's new mental hospital. Bill remembers that his father also provided food for the family's meal more than once by shooting game that got too close to his office window.

Later, they moved to the state's capital city, where the Oklahoma City Clinic was founded in 1919 by Dr Rucks and five other physicians. They also purchased Wesley Hospital, forerunner to today's Presbyterian Hospital.

A year later, Bill matriculated at the Webb School. In its nearly fifty-year existence, the school had established a distinguished scholastic reputation throughout that region of the country. Dr Rucks knew about the school and its notoriety because he had attended Vanderbilt University, located in nearby Nashville, Tennessee.

In 1920, the school's campus included three old wooden buildings on about 100 acres of land studded with huge birch trees. Since there were no dorms, the 200 or so students boarded with thirty to forty families in Bell Buckle (population 500 sans boys). Room and board were \$25 a month, and tuition was \$150 a year.

All students pledged to abide by the rules and those caught cheating were dismissed or severely reprimanded. Among other things, no firearms, drinking, or smoking was permitted.

Chewing tobacco, however, was okay, and there were spittoons in each of the classrooms. Perhaps it was no coincidence that the Webbs were habitual chewers. During Bill's first day there, old Sawney Webb spoke to the student body for four straight hours, stopping periodically to step down from the pulpit and spit into a can.

The school day began with chapel and proceeded through Latin, Greek, mathematics, history, English, and physics, which was optional.

A potbelly stove was in the center of each classroom, which was framed by blackboards and

**Bill Rucks  
and colleague  
Jack Records  
have been  
swapping  
stories at the  
Oklahoma  
City Clinic  
since 1939.**



ong benches to accommodate the “trapping system” of grading.

Initially, the boys lined up randomly on the benches. A question was asked of boy number one. If he answered it correctly, he stayed put; if his answer was incorrect and boy number two answered correctly, he would move up, and so on. At the end of the session, whoever was in spot number one received a distinction and, according to Bill, the utmost respect from his peers, at least for that day. Grades were based on a student’s relative positions throughout the grading period.

“I never worked so hard in my life as I did that first year,” Bill remembers. “I was so far behind the others, particularly in Latin and Greek, that . . . well, the proudest I ever was of a grade was a 53 on the final Latin exam on the poet Ovid. Fifty was passing.”

During the second year, Bill did considerably better and thrived on the fierce competition both inside and outside the classroom.

A decade later, Vermont Royster, the former editor of *The Wall Street Journal*, attended the Webb School. His evaluation of the experience practically mirrored Bill’s. In his autobiography, Royster wrote that “those were the most momentous years of my life.” The school “gave me a quiet time for growing up in a place where learning was valued for its own sake.”

In paraphrasing Son Will (who by then had ascended to headmaster), Royster said it was

considered essential to learn to live by rules — whatever they are — in order to live in the world. So arbitrary rules were made up to teach discipline and self-discipline.

Like most boys who graduated from Webb School, Bill has long since forgotten the rules governing ablative absolutes and how to conjugate certain Latin verbs. However, he absorbed the truly important legacies of the school and used them throughout his long medical career.

**B**ill spent the Roaring Twenties and then some in Tennessee. After graduating from Webb in 1921, he moved forty miles north to Nashville, where he attended Vanderbilt. While living in the Sigma Chi fraternity house, he managed to have both a good time and good grades.

At one of the fraternity parties, he met a coed named Louise Earthman. Though Bill was attracted to her, he was about to start medical school at Vanderbilt and could brook no serious distractions . . . at least not then.

After three undergraduate years, Bill entered medical school in a program that enabled him to obtain a bachelor’s degree in biology following his first medical school year in 1925.

Vanderbilt was generally considered to be one of the top ten medical schools in the nation. Unlike most medical schools at that time, Vanderbilt’s faculty mainly consisted of fulltime career teachers.





***It was 120° in California in 1942 when Bill arrived to set up an evacuation hospital. "The air was so dry that you didn't sweat, but you sure did get salty after a while," he quips.***

Nevertheless, the first year was characteristically a grind. "We spent from eight in the morning till noon dissecting cadavers and learning every single nerve and blood vessel . . . everything," says Bill. "There was microscopic anatomy most of the afternoon and then studying till midnight or so."

Bill remembers only one fellow in that class who didn't graduate and he dropped out on the first day of gross anatomy. "He sat there for a time staring at the cadaver, and then he just got up and walked out."

During vacations, Bill visited his parents and usually shared one of his medical school problems with his father: "I told him I needed more money."

Bill continued to see Louise some, but their relationship was essentially unchanged through medical school. "Back then, medical students didn't get married," Bill says. "Wives were too much of a diversion for someone who was supposed to be

spending every waking moment learning medicine.

"I think only one member of our class was married and he was thirty-two years old. One guy announced he was getting married during his senior year, and we honestly thought he'd lost his mind."

Bill Rucks received his MD in 1928. Two years later, during his internal medicine residency at Vanderbilt, Bill and Louise apparently "lost their minds" and got married. Also during his residency, Bill spent six months in Boston on the neurology service at one of the Harvard teaching hospitals. According to his friend Dr Jack Records, Bill was interviewed by one of the great pioneers of neurosurgery, Dr Harvey Cushing of Harvard, for a neurosurgery residency there.

He also was invited by Vanderbilt to join the medical school faculty. Though he was flattered and actually considered accepting, the lure of joining his

father at the Oklahoma City Clinic proved too strong. So, after he completed his residency in 1931, he and Louise packed up and moved to Oklahoma City.

They had been preceded by a few months by Dr Ben Nicholson, a Vanderbilt classmate of Bill's, whom he had recruited for the Oklahoma City Clinic. Nicholson, a pediatrician, had such a distinguished career in Oklahoma City that one of the towers of Oklahoma Children's Memorial Hospital was named after him.

Bill Rucks became the seventh physician at the Oklahoma City Clinic (and the second named Bill Rucks). Though the clinic was well established by then, so, too, was the Great Depression. The number of patients was down, Bill says, because many people who couldn't pay any longer were too proud to accept 'charity.'

"I remember times at the clinic when the doctors would be sitting around playing cards," he continues. "We didn't care about the money — nobody was making much anyway — but the patients just weren't coming through the door."

Nevertheless, as a young man just beginning his medical career, Bill was hungry for experience. He joined the volunteer faculty at the University of Oklahoma medical school, a position he held, long after he needed any more experience, for five decades.

Practicing medicine was fun throughout the thirties, according to Bill. It was, he says, the beginning of the "Golden Age of Medicine." Medical advances, particularly the new sulfa drugs for treating infectious diseases, were enabling physicians to increase the quality of medical care — without the burden of the red tape that was to become characteristic of the profession after the early 1960s.

In 1939, obstetrician-gynecologist Jack Records joined the clinic. He remembers meeting Bill Rucks for the first time during an evening of penny-ante poker at Dr Austin Bell's house. "It's a wonder that I remember anyone from that evening because the real attraction was the Bells' new Bendix automatic washmachine," Records says. "But, I think it was his sense of humor that I noticed first. And he was a terrific needler, particularly of my wife."

It was at another of these floating poker games just before Thanksgiving a year later, that thirty-six-year-old Bill made a startling announcement. According to Records, the poker party had been going on for quite a while when Rucks suddenly showed up and said he had volunteered to join the army. "In today's vernacular," Records says, "Louise about 'stroked out.'"

Actually, Bill and several other OU-affiliated doctors had organized a unit that could be used to staff a field evacuation hospital when, in their opinion, the US inevitably would enter the war. After Pearl Harbor the unit was activated, and Bill and the others suddenly found themselves putting up an evacuation hospital near Needles, California.

"When we got off the troop train, it was 120 degrees," Bill remembers. "I thought, 'My God, I don't know if I can tolerate this.' The air was so dry that you didn't sweat, but you sure did get salty after a while."

The idea was to train armored divisions in an environment similar to where they would be heading: the desert campaigns in Africa. The field hospital was run so efficiently by Rucks and others that they were assigned there for a year. "When we finally got the word that we were to be shipped out somewhere in the South Pacific," Bill says, "you'd have thought the war had ended what with all the cheering."

Captain Rucks was named chief of the medical service of the 21st Evacuation Hospital in September 1942. Their location, however, wasn't the deserts of North Africa, but a small jungle island in the Solomon chain: Guadalcanal.

The fiercest fighting for control of the 2,500-square-mile island was over by September, but it took the American marines five more months to secure it. During the worst of the fighting, Rucks and his medical service worked mainly to keep the casualties alive prior to surgery.

Yet most of those battles and skirmishes were fought on the other side of the island. When the 21st was sent a hundred miles north to Bougainville, the hospital was established on a small slice of beachhead, which was all the marines had taken to that point. The well-dug-in Japanese controlled all the rest.

There was almost constant combat the first few weeks and a "huge number of casualties," Rucks says. "At times, we were within 300 yards of the fighting, and artillery was whistling over our heads all the time, at least it seemed like."

Fortunately, the hospital never was hit, so the medical and surgical services continued working around the clock. Then, as the combat ebbed, the doctors began contending with the massive number of troops who had developed malaria.

"We treated literally hundreds and hundreds of soldiers with malaria," Bill relates. "One unit had a





***Commenting on his decision to retire, Rucks says, "Actually, it occurred to me one day that if I were a patient, I wouldn't want to go to an eighty-year-old doctor . . . and that was it."***

malaria incidence of 120 percent. We'd treat them about ten days or less and send them back to their units."

Many years later, an OU medical student casually asked Bill one day if he'd ever seen a case of malaria. Bill thought a moment and replied matter-of-factly: "About 10,000."

They also treated plenty of cases of an infectious disease called "scrub" typhus. Carried by a mite, this disease was said to have had up to a fifty percent mortality rate on some of the other islands. "The men with scrub typhus got very ill and there was no specific cure," Bill says. "Fortunately, the worst of the fighting was over, and we had the time to treat them symptomatically and watch them real closely . . . and we didn't lose a one. That was something we all were proud of."

Later, he also had time to fish, his favorite pastime since childhood, and fishing off Bougainville was like nothing he'd experienced before. "We'd go to a place called Empress Augusta Bay and reel in enough bonita and mackerel to feed the forty or so people in the officers' mess. Some battalions kept themselves supplied with these fish, caught in a different way. They'd throw dynamite charges in the ocean and then go around and scoop up all the stunned ones."

Bill spent about a year in Bougainville. Then, in January 1945, the 21st Evacuation Hospital personnel were in on the campaign to retake the Philippines. They followed the frontline troops inland from the Lingayen Gulf to the town of San Carlos. There they established a hospital in an abandoned church, constructed by the Spanish in the sixteenth century.

Though he had been in imminent peril for weeks in Bougainville, Rucks didn't think he might really be killed until a noncombat incident occurred in the little Filipino town. To thank their liberators, the residents held a party complete with speeches and a dance band in the town square, adjacent to the hospital.

The incident was sparked when the black GIs were not permitted to dance, and some of them started firing their pistols in the air. Rucks, who was working in the hospital, thought it was a surprise Japanese attack. He told all the patients to get on the floor and ran for his carbine. "I thought, 'This is it,' but the commotion ended as quickly as it began."

After a few months, Bill and the 21st moved their hospital to a suburb of Manila. In fact, the structure, made of Quonset huts, was located on and about the seventeenth green of the posh Wac-Wac golf and country club.

One day the commanding officer sent for Rucks and said that General MacArthur's wife would be arriving shortly and wanted to see him. Thinking he was joking, Rucks replied that he might be a little late . . . "You see, I'm having tea with Mrs Eisenhower just now."

This perceived impertinence was handled with dispatch and Rucks was sent off to get the wards presentable. Soon, Jean MacArthur did arrive and visited with Bill, whose wife, Louise, and Mrs MacArthur were friends who corresponded periodically.

All through the summer of 1945, preparations for the invasion of Japan continued. Much of one of Manila's major thoroughfares, Taft Boulevard, was being turned into a vast hospital row in anticipation of the tens of thousands of expected casualties.

The 21st Evacuation Hospital figured to be in on the invasion, something Bill Rucks dreaded. "We all knew that there would be a terrible number of casualties, but as the thing got closer to happening, I developed an unholy fascination with it. The invasions we'd been in on before were minor compared to the prospect of invading Japan. I thought this would be the greatest invasion of all time, and I'd really hate to miss it."

In August, Bill heard some scuttlebutt in Manila about some air force officers offering to bet \$100,000 that the war would be over in less than two weeks. Preposterous, he thought, but after the second atomic bomb was dropped on August 9, the war was indeed over.

**T**hat autumn, Bill was back doctoring at the Oklahoma City Clinic. It took awhile to get reacclimated. He had become an expert at treating tropical diseases, shock, and combat wounds, but there wasn't much call for such expertise at the clinic.

Furthermore, he found he was annoyed by some of his patients' "trivial complaints," especially compared to the stoic suffering of most of the infantrymen he'd treated. "Sometimes, I'd just have to tell them, 'Gee, my heart really bleeds for you.'"

On a busy day, Bill would make hospital rounds and see about ten patients in his office. As with perhaps most internists, the majority of his patients had "self-limiting disorders." That is, they would do well no matter what.

Earlier in his medical career, he says, he was more interested in his patients' illnesses than in the patients. However, by the 1950s, he had decided that

a good internist's chief asset was offering reassurance to his patients. "It is probably the strongest therapeutic weapon you can offer, after conducting a good history and physical."

Of course, some patients need constant reassurance, Bill says. One of them once told him, "I know I'm a hypochondriac, Doc, but don't all of us hypochondriacs die of something sooner or later?"

He spent at least half a day per week teaching students and residents at OU-affiliated teaching hospitals. Characteristically self-effacing, Rucks says he got as much as he gave. "The teaching boosted my self-confidence professionally because I knew I always had to be on my toes. The medical students and housestaff were getting smarter and more sophisticated over the years — or maybe this observation is a reflection of my own decline," he adds with a wry grin.

Dr Ted Clemens, the chief of staff of Oklahoma City's Presbyterian Hospital, has observed Rucks's abilities from various perspectives: as an OU medical student and medicine resident in the 1950s, and later as a colleague at the Oklahoma City Clinic and Wesley and Presbyterian hospitals.

"Many of the internists in town thought of Bill as sort of a lion of medicine," Clemens says. "You had to be impressed by the way he took care of his patients. He was scrupulously honest with them, no matter who they were — even the ones we used to call 'neurotic.'"

Bill Rucks did the OU medical school a big service in the early 1950s, Clemens says. "As head of the search committee that hired the first fulltime





# Oklahoma City Clinic

701



chairman of the medicine department, Bill was mainly responsible for attracting Dr Stewart Wolf from Cornell. When Stewart came out here to look over the place, I imagine he thought he was in a wilderness, relatively anyway.

"But right off he liked Bill, who convinced Stewart that coming here would be a worthy challenge," Clemens continues. "Stewart accepted the offer and began the job of creating a first-class department of medicine."

Clemens also was impressed by Bill's administrative ability when, during the 1960s, Bill was both president of the clinic and chief of staff at Presbyterian. Bill, he says, could quickly see to the heart of a problem, divine a person's real motivations, and use humor effectively — all sterling qualities in someone who runs a lot of meetings. And many meetings there were, with Bill at one time or another having been president of the Oklahoma Internists Society, the Oklahoma City Academy of Medicine, and the Oklahoma County Medical Society, as well as governor for Oklahoma in the American College of Physicians.

Bill's stewardship came during a decade when technological and economic forces were increasingly influencing the practice of medicine. He was able to accommodate the changes, Jack Records says, while maintaining his equilibrium and integrity.

He found the trend toward increasing specialization and gadgetry "annoying." At least ninety percent of all the problems treated by subspecialists, Bill maintains, could be treated by a good general internist. "Of course, they wouldn't agree with that," he says, grinning.

Bill also was "annoyed" by the changes in financing of medical care resulting from Medicare, but he says the program has been a "godsend" to the nation's elderly. "I have no fear that the government is going to take over medicine. And what if I'm wrong? Look at England and Sweden; medicine is practiced on a very high plane in those countries. And that's the point: the fundamentals of diagnosing and caring for patients remain largely unchanged."

**T**he Oklahoma City Clinic always has had a mandatory retirement age of sixty-five, so when Bill reached that age in 1968, he retired administratively. However, he was allowed to maintain an office there from which to continue his practice.

That same year he spent two months as a visiting professor of medicine at the Medical School of Saigon

***"Many of the internists in town thought of Bill as sort of a lion in medicine," recalls Ted Clemens in describing some of Rucks's busiest years.***

in South Vietnam. As an attending physician at two Saigon hospitals, he conducted rounds each morning with medical students and medicine residents. Language was the most formidable barrier, he remembers. "The students took histories in Vietnamese, wrote them in French, and were supposed to discuss them in English, though this was the first year that English was required. Though I knew virtually no French, I think I learned more from their notes than I did their spoken English."

During the 1970s, he made more time for traveling. He and Louise went around the world in five or six weeks. They visited Russia, India, and Japan, but they didn't stop on any of the Pacific islands where he'd spent the war. "I sort of wanted to, but for some reason just didn't," Bill says.

Perhaps it was just as well. A few years ago, one of his doctor friends arranged a stopover on a little island near Bougainville. "Their plane mistakenly took off without him and his wife, a woman who thinks 'roughing it' is a weekend at the Waldorf," Bill comments. "There was no apparent transportation, but eventually this doctor paid some natives to take them by boat to an island with some air service.

"Well, the boat was a canoe, which these natives had to paddle in open seas for a number of miles," Bill continues. "Getting his wife to safety turned out to be more harrowing than anything he did during the war."

He and Louise did go on a 2,200-mile boat ride down South America's Amazon River, but, admits Bill, "it wasn't exactly the kind of adventure where



we were fighting off unfriendly natives and crocodiles. Actually, the ship was air conditioned and had a good bar."

Then, a few years ago, he took two of his teenage grandchildren on a safari in Kenya. Once again, instead of bivouacking by a jungle trail, Bill and his wards spent their evenings in plush accommodations, lodges — with good bars.

This trip was arranged just after Presbyterian Hospital and the OU College of Medicine established the William W. Rucks, Jr., Fellowship in Internal Medicine. Though Ted Clemens had a role in the fellowship's development, he says the idea came from Harry Neer, the former president of the hospital. "He'd heard so many of us talk about the impact Dr Rucks had had on our careers, that he felt the trustees should do something in his honor," Clemens says.

The ceremony was held in November 1979 in the ballroom of an Oklahoma City hotel. The program was presided over by Clemens and the guest speaker was Stewart Wolf, who many years before had left OU for Saint Luke's Hospital in Bethlehem, Pennsylvania.

When a newspaper reporter asked Rucks about the fellowship, he, as usual, downplayed it. "The hospital wanted to do something so they could keep a resident on an extra year if he had a special project. They just named it after me. I don't have a darned thing to do with it."

Clemens says all the hoopla surrounding the establishment of the fellowship probably embarrassed Rucks to some extent, "but when he made his acceptance speech at the dinner, he said he had to admit that the whole thing had been sort of fun and that he'd gotten used to it."

The reporter also asked him about retirement. He said anytime he thinks about retirement, "I decide I'll think about it later." Finally, two years ago, he decided he couldn't put off the inevitable any longer. "Actually, it occurred to me one day that if I were a patient, I wouldn't want to go to an eighty-year-old doctor . . . and that was it."

Possibly his decision also had something to do with his wife, Louise, who has been chronically ill in recent years. Her condition also has precluded his carrying out an idea that he mentioned to Clemens some years ago. "Bill said, 'Wouldn't it be great to rent an apartment for three or four months in each of several major American cities.'"

Nowadays Bill Rucks visits his small office in the new Oklahoma City Clinic a few days each week. He reads his mail and some medical literature and "somehow manages to remain occupied." A couple of days a week he tries to go to lunch at Presbyterian with Jack Records or some other old friends. "You know," he says, as he walks past the fountain on the clinic's main floor, "I don't even know some of the newer doctors here anymore. It's strange after all these years. But I guess it's just part of growing up." □

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## *Hypertension I*

# The Relationship of Hypertension to Serum Cholesterol, Triglycerides, and Sodium

ASEGASH TSEGAYE, PhD; CHARLES R. RITCHEY, MS; and ROBERT D. MORRISON, PhD

One hundred thirty-six people from five communities in Oklahoma were studied to see if a relationship could be established between some blood components and essential hypertension. In this population, 22% of the people were found to be hypertensive and 78% normotensive. Using the cholesterol/HDL cholesterol ratio as a method for predicting risk of coronary heart disease, 75% were found to have normal risk while 25% were of high risk. The concentrations of serum cholesterol, HDL cholesterol, triglycerides, and potassium were found to be different among the races; however, there was no difference in the concentration of sodium. Of all the parameters measured, only serum triglycerides were found to have a positive correlation with blood pressure.

Essential hypertension is a chronically elevated blood pressure for which the exact cause is unknown. It is a major medical problem in the United States, with one out of every four adults suffering from hypertension. Hypertension is almost twice as prevalent among blacks as among whites.<sup>1</sup> In the Framingham study it was shown that among people aged 30 to 62 years, hypertension was the chief cause of congestive heart failure.<sup>2</sup> Abnormally high blood lipid levels have been implicated as a cause of hypertension, with

approximately 40% of the American diet being composed of fat.<sup>3</sup>

One component of the blood lipids is the lipoproteins. The lipoproteins are classified according to their density as high density (HDL), low density (LDL), and very low density (VLDL). Castelli et al<sup>4</sup> and Gordon et al<sup>5</sup> showed that the level of HDL cholesterol is significantly lower in people with coronary heart disease (CHD) than in people with normal levels of HDL cholesterol.

Although the relationship between diet and total cholesterol, HDL cholesterol, and triglycerides has been studied, there appears to be no clear-cut evidence linking this relationship to CHD.<sup>6-8</sup> It has been reported by several investigators that there is a relationship between CHD and levels of total serum cholesterol and HDL cholesterol. People with relatively high levels of HDL cholesterol and low levels of total cholesterol showed a low incidence of CHD.<sup>9-14</sup> High levels of triglycerides have also been associated with a high risk of CHD.<sup>12</sup> Cigarette smoking has been identified as a factor that lowers HDL cholesterol levels, while moderate alcohol intake and exercise are factors that increase HDL cholesterol levels.<sup>11,12,15</sup> In addition, Hartung et al<sup>16</sup> showed that there is a difference in the levels of total cholesterol, triglycerides, LDL cholesterol, and HDL cholesterol among marathon runners, joggers, and sedentary men. Van Gent et al<sup>17</sup> indicated that there is a negative relationship between serum HDL cholesterol levels and oral contraceptives and obesity.

This paper reports on the results of further studies of the various blood parameters and their statistical

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Table 1. — Intercepts and Slopes of Simple Linear Regression of Blood Values on Age

	BLKF			BLKM			WHTF			WHTM		
	Inter	Slope	Sig	Inter	Slope	Sig	Inter	Slope	Sig	Inter	Slope	Sig
Cholesterol	168.64	0.754	0.01	244.44	-0.404	0.35	144.16	1.372	0.01	108.81	1.744	0.02
HDL cholesterol	57.99	0.030	0.74	62.37	0.180	0.25	38.43	0.265	0.08	38.78	0.150	0.57
Cholesterol/HDL cholesterol	3.13	0.011	0.16	4.27	0.004	0.80	3.70	0.013	0.34	4.02	0.023	0.33
LDL cholesterol/HDL cholesterol	1.77	0.012	0.10	2.64	0.003	0.66	2.29	0.011	0.28	2.77	0.014	0.44
Triglycerides	75.37	0.236	0.49	130.05	-0.542	0.50	80.33	0.714	0.35	38.75	1.897	0.17
BUN	9.74	0.080	0.01	10.56	0.078	0.13	5.36	0.171	0.01	3.27	0.275	0.01
Sodium	139.31	0.027	0.03	138.06	0.036	0.09	138.61	0.044	0.03	140.53	0.011	0.75
Potassium	4.21	-0.001	0.85	4.49	-0.007	0.16	4.00	0.010	0.03	4.59	-0.004	0.66
Systolic pressure	94.81	0.665	0.01	113.89	0.324	0.11	101.46	0.460	0.02	96.31	0.554	0.11
Diastolic pressure	65.40	0.226	0.02	63.82	0.325	0.04	72.19	0.128	0.38	65.51	0.276	0.29

BLKF = black female; BLKM = black male; WHTF = white female; WHTM = white male

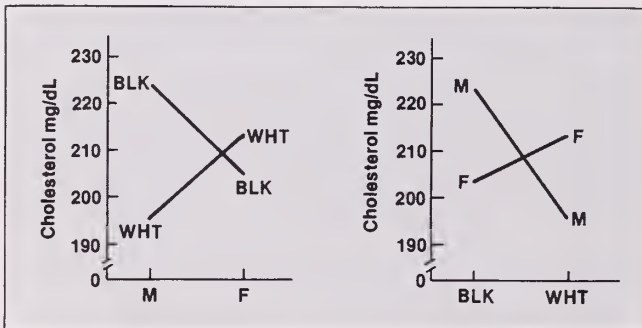


Figure 1. The level of serum cholesterol adjusted to age 50

correlation to hypertension. Total cholesterol, HDL cholesterol, triglycerides, sodium, potassium, and blood pressure were studied because of their involvement with CHD. To rule out secondary hypertension caused by kidney disease, blood urea nitrogen (BUN) was measured and urinalysis was performed.

## Materials and Methods

**Sampling.** One hundred thirty-six volunteers from the five Oklahoma communities of Boley, Guthrie, Langston, Muskogee, and Okemah were studied in an effort to determine the relationship of diet and hypertension. These volunteers were instructed to fast for 12 hours prior to the drawing of the blood samples. Each person was sampled twice with an interval of one week between samplings.

The blood samples were drawn in Vacutainers® and allowed to clot. (The use of names of trademarked items does not imply an endorsement of these items; it is intended only as an example.) The clotted blood was centrifuged and the serum was drawn off. The samples were transported from the site of collection to the laboratory in an insulated box at 0°C to 3°C.

All samples were analyzed within 48 hours. When storage of the serum was necessary, the samples were refrigerated at 3°C.

**Methods of Analysis.** Blood samples collected in Okemah were analyzed by the Medical Arts Laboratory, Oklahoma City, using Technicon methodologies. All of the other blood samples were analyzed in our laboratory using the following Sigma Chemical Company procedures: total cholesterol and HDL cholesterol were determined by No. 350-HDL; triglycerides by No. 405; and BUN by No. 640. A Gilford model 250 spectrophotometer equipped with a rapid sampler was used to analyze cholesterol, HDL cholesterol, triglycerides, and BUN. Sodium and potassium were analyzed using a Coleman model 51-Ca flame photometer.

The samples were analyzed in batches. A standard curve was prepared for each of the batches. Samples were run in duplicate. Commercial normal and abnormal serum controls (Fisher, General Diagnostics, and Sigma) were analyzed with each batch as quality controls, and the values obtained by analysis were comparable to the stated values in each case.

**The Statistical Analysis.** All the blood data were adjusted to age 50 for each race and sex since there was a linear relationship between the response variable and age. The values adjusted to age 50 years were then analyzed in a two-way classification factorial experiment in which one of the factors was race and the other was sex. This is a two-by-two factorial in which the pooled variation among subjects within races and sexes was used as an experimental error. The means for race-sex groups were used to compare the difference between the races, the difference between the sexes, and the interaction of races and sexes.

Table 2. — Mean Values of Serum Parameters Adjusted to Age 50

Race & Sex*	Cholesterol mg/dL	HDL mg/dL	Chol/HDL	Triglycerides mg/dL	BUN mg/dL	Sodium MEq/L	Potassium MEq/L
BLKF (58)	206.34	59.52	3.71	91.65	13.75	140.67	4.19
BLKM (20)	224.37	53.37	4.45	102.94	14.47	136.86	4.16
WHTF (35)	212.74	51.68	4.33	116.01	13.91	140.80	4.51
WHTM (17)	196.01	39.28	5.19	133.58	17.02	141.10	4.41

\*The numbers in parentheses indicate the number of participants

## Results

Table 1 shows the intercepts and slopes for the simple linear relationships between the ten blood parameters and age for each race and sex. It was found that of the 40 possible slopes, 13 were significantly different from zero at the 0.05 probability level.

Since people often associate cholesterol with hypertension and CHD, it was decided to begin the evaluation with this variable. Investigation of the data indicated that some of the response variables are age related. For example, as a person ages, cholesterol values increase. (The word *cholesterol* as used throughout the results and discussion means "total cholesterol" unless otherwise defined.) However, it should be noted that the change in cholesterol with respect to age for a black woman may not be the same as that for a white woman (Table 1). As the black woman's age increases, the serum cholesterol level is expected to increase by 0.8 mg/dL per year (Table 1).

There is a decrease in the level of serum cholesterol as the age of a black man increases, but this decrease is not significant. Previous studies have shown that the cholesterol level increases as people age.<sup>4</sup> However, in the data we examined, there were two teenage black men with very high cholesterol values which caused the relationship between cholesterol and age to decrease. Anomalies such as this may be expected when the sample size is small.

As the age of a white woman increases, the serum cholesterol level is increased by 1.4 mg/dL per year, and for a white man this increase is 1.7 mg/dL per year. Therefore, in order to look at differences in serum cholesterol levels between black women, white women, and white men, age must be taken into consideration. In this study, it was found that a linear relationship occurred between the cholesterol variable and age for each race and sex group. This response variable was adjusted to an average age of 50

Table 3. — Summary of Analysis on Variance on Age-Adjusted Blood Parameters

	Race	Sex	Interaction
Cholesterol	†	†	*
HDL cholesterol	**	**	NS
Cholesterol/HDL cholesterol	**	**	NS
Triglyceride	*	NS	NS
BUN	NS	*	NS
Sodium	NS	NS	NS
Potassium	**	NS	NS
Systolic pressure	NS	NS	NS
Diastolic pressure	NS	NS	NS
LDL/HDL	**	**	NS

† Main effects cannot be interpreted owing to type of interaction. Simple effects are discussed.

\* Significant at the 0.05 probability level

\*\* Significant at the 0.01 probability level

NS Not significant

years because the average age of people in this study was approximately 50 years. By making this adjustment for age, it was possible to look at the differences between the races, sexes, and sexes within the races.

Figure 1, which was drawn from the data in Table 2, shows the relationship between sex and race means for cholesterol, adjusted to 50 years of age. The statistical analysis shows that there is an interaction between race and sex, which is seen by noting that the two lines in Figure 1 are not parallel. Since interaction exists (Table 3), we looked at differences due to sex within the white and black groups, then between the races among the men and between the races among the women. There is a difference in the concentration of serum cholesterol for the two visits. The concentration of serum cholesterol found on the second visit was lower by 9.67 mg/dL. We have no explanation for this other than that people might have



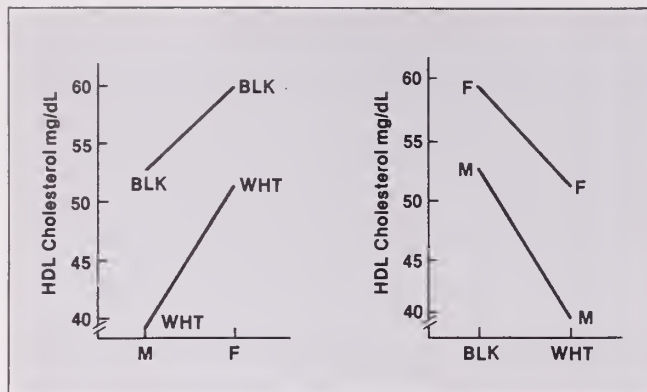


Figure 2. The level of serum high density lipoprotein cholesterol adjusted to age 50

watched their diets more closely during the study period; however, other investigators have also observed this effect.<sup>18</sup> We feel that reporting the results of the second visit would therefore be misleading, so we restricted our evaluation to the first visit. There was very little or no difference between visits one and two with respect to the other blood parameters.

Serum cholesterol has a positive correlation with serum triglycerides, and LDL cholesterol/HDL cholesterol at the 0.01 probability level and with potassium at the 0.05 probability level. To our knowledge, no literature has reported the potassium effect. We found no correlation between serum cholesterol and sodium or blood pressure.

Although age has little or no effect on the level of HDL cholesterol, we still used the 50-year adjusted value as shown in Table 1. White men have the lowest levels of HDL cholesterol among the sexes and races (Table 2). There is a significant difference in the level of HDL cholesterol between the two races and between the two sexes (Table 3 & Fig 2). High-density lipoprotein cholesterol has a negative correlation with the LDL cholesterol/HDL cholesterol ratio, with triglycerides, and with the cholesterol/HDL cholesterol ratio at the 0.01 probability level. We found no correlation between the level of HDL cholesterol and age, blood pressure, blood urea nitrogen, sodium, and potassium.

This study showed that as the age of a black woman increases, the serum triglyceride level is increased by 0.2 mg/dL per year. On the other hand, the increase is 0.7 mg/dL per year for a white woman. As the age of a black man increases, the serum triglyceride level is decreased by 0.5 mg/dL per year, and as a white man ages the triglyceride level is increased by 1.9 mg/dL per year (Table 1 & Fig 3). There is a significant difference in the level of serum triglycerides between the races; however, there appears to be no interaction between the races and the

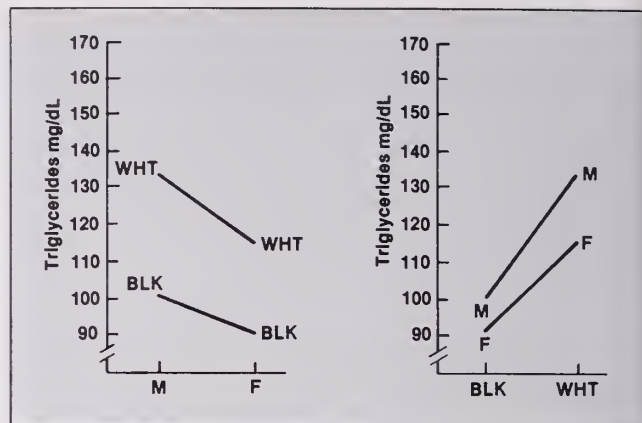


Figure 3. The level of serum triglycerides adjusted to age 50

sexes. A positive correlation exists at the 0.05 probability level between the level of serum triglycerides and age, while there is no apparent correlation between triglycerides and blood urea nitrogen, sodium, or potassium.

There is a significant difference in the level of blood urea nitrogen between the sexes and in the level of serum potassium between the races (Table 3). Age has a significant effect on the level of serum sodium in both the black and white women. On the other hand, age has a significant effect on the level of serum potassium only in the white women (Table 1). Systolic blood pressure increases significantly as the women grow older, while the diastolic blood pressure increases with age only in the blacks (Table 1).

## Discussion

It has been shown that people with blood pressure above 140/90 mmHg (systolic/diastolic) are predisposed to CHD.<sup>19</sup> Therefore, for the purpose of this study a person was considered hypertensive if his/her diastolic blood pressure was 90 mmHg or above. By this definition, of the 136 people studied, 30 (22%) were hypertensive and 106 (78%) were normotensive. The risk of CHD and stroke can be predicted by using the cholesterol/HDL ratio<sup>4</sup>; a cholesterol/HDL cholesterol ratio above 4.97 for men and 4.44 for women is considered to be high risk. Another method used to predict risk for CHD was the LDL cholesterol/HDL cholesterol ratio<sup>5</sup>; a ratio above 3.6 is considered high risk. In this study, 102 people (75%) were found to have a normal risk considering the ratio of cholesterol to HDL cholesterol. Thirty-four members (25%) of this population were high risk and one person was found to be at very high risk for CHD and stroke. Using the LDL cholesterol/HDL cholesterol ratio, 83% of the population measured had a normal risk factor and 17% had an increased risk of CHD and stroke.

Using the cholesterol/HDL cholesterol ratio, it was found that the risk factors for CHD are lower in women (22%) than in men (34%), a result which is in agreement with that of the Framingham study.<sup>5</sup> One out of four people will be found to have increased risk of developing CHD and stroke, whereas using the LDL cholesterol/HDL cholesterol ratio will show one out of six people to have an increased risk of developing CHD and stroke.

Like Kwiterovich,<sup>20</sup> we found that there is a difference in the level of serum cholesterol and triglycerides among the different races and sexes. The increase in triglyceride levels was more pronounced in white men. Both black men and black women have lower levels of triglycerides than do white men and white women (Fig 3). Brockway<sup>21</sup> found that an individual's cholesterol and triglyceride levels increase with age; our study showed that age has no effect on triglyceride levels, but does have an effect on cholesterol levels in all groups except the black men.

White men have the lowest HDL cholesterol level among the sexes and races; they also have a lower level of cholesterol than do the black men and both black and white women (Table 2 & Figs 1 & 2). Both black and white women have higher levels of HDL cholesterol than either black or white men; also, these women have a lower level of cholesterol than the black men. In general, then, women have a lower cholesterol/HDL cholesterol risk factor than men.

A positive correlation was found between serum triglyceride levels and blood pressure. While we did not find correlations of serum cholesterol and HDL cholesterol with blood pressure, this does not necessarily mean they do not have some role in CHD. It is interesting to note that approximately 22% of the population was considered hypertensive as compared to the 25% at high risk when measured by the cholesterol/HDL cholesterol ratio. □

"Hypertension II: Statistical Correlation of Seventy-eight Diet Components to Blood Pressure" will be published in the November 1985 JOURNAL of the Oklahoma State Medical Association.

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# A Chronic Illness and Geriatric Assessment, Evaluation, and Rehabilitation Unit

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**In January 1981 a program for the assessment, evaluation, and rehabilitation of elderly or chronically ill patients was established at the Oklahoma Health Center. The following report describes the program's purpose and activities.**

The first inpatient geriatric unit was established in England a number of years ago,<sup>1</sup> and many similar units have since been established in the United States.<sup>1-5</sup> The organization and structure of these units vary, but most include interdisciplinary medical and functional assessment with some effort at rehabilitation. The major goal has been to improve the patient's quality of life, which may be enhanced by any one or a combination of the following elements: improvement in social, psychological, or functional mobility, and the prevention of institutionalization.

The patients in these units typically have been debilitated and functionally impaired persons over 60 years of age. Although there is a general correlation between chronologic and biologic age, chronically ill persons under age 60 often require similar medical, social, and psychological services. Hence an assessment, evaluation, and rehabilitation program for both chronically ill and elderly persons was established in January 1981 at the University of Oklahoma Health Sciences Center, O'Donoghue Rehabilitation

Institute and Veterans Administration Medical Center in Oklahoma City.

The service consists of a multidisciplinary consultation and evaluation team. The team includes internists, a urologist, a neurologist, an orthopedic surgeon, a psychologist, an occupational therapist, a physical therapist, a social worker, a dietitian, and a geriatric caseworker. Before a final program is written, patient consultations at the OUHSC, VAMC, and six Oklahoma County community hospitals are conducted by an internist, a geriatric case manager, an occupational and physical therapist, and a psychologist. The consultations may be either at the hospital where the patient is being treated or at the O'Donoghue Rehabilitation Institute's Outpatient Clinic.

Patients referred may be divided into three groups:

- Group I. Patients for whom recommendations are readily implemented or for whom no further assessment or rehabilitation is deemed necessary;
- Group II. Patients whose assessment and rehabilitation are addressed on an outpatient level (one segment of this group reported previously [Stress Incontinence<sup>6</sup>]); and
- Group III. Those patients who, after evaluation and assessment, are deemed good candidates for intensive rehabilitation.

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Table 1. — Admission Statistical Data

Admission Characteristics	Number	Percent
Admissions	200	
Discharges	197	
Average age (years)	61.9	
Males	88	(44%)
Females	112	(56%)
Race/White	150	(75%)
Average # of diagnoses	4.25	
Admitted from nursing home	19	(10%)
Scheduled for nursing home	37	(18%)
Confined to bed, wheelchair, or needing constant assistance with ambulation	175	(87.5%)
Incontinent of urine or had indwelling urinary catheters	72	(36%)

This report describes and compares the condition, on both admission and discharge, of the first 200 Group III patients admitted to the Medical Service at the O'Donoghue Rehabilitation Institute. Group III patients constitute about 45% of the total number of patients referred and seen by the service.

## Materials and Methods

The Chronic Illness and Aging Program is within the Department of Medicine, University of Oklahoma Health Sciences Center, and the Veterans Administration Medical Center. The Inpatient Unit is a 16-bed ward located in the O'Donoghue Rehabilitation Institute, which is part of the University of Oklahoma Teaching Hospitals. This report covers the first two years of operation of this unit, from July 1981 to July 1983. Although referrals came from nursing homes and hospitals, both local and statewide, the majority came from Oklahoma Memorial Hospital and the Veterans Administration Medical Center. The criterion for admission is simple: there is a distinct probability that the quality of the patient's life can be improved.

During the first 7 to 10 days in the unit, each patient undergoes a multidisciplinary assessment and evaluation. The attending physician, a resident (internal medicine), and a physician's assistant determine the patient's clinical status as well as identify problems with medications and acclimatization to the new environment. A psychologist evaluates memory, motivation, and any depression or psychosocial problems. Nursing staff members assess communication ability, motivation, skin care, continence, and acclimatization to the new environment. Physical therapists test for range of motion, mobility, and physical endurance. Occupational therapists assess the patient's endurance and ability to cope with the activities of daily living. Social service workers

Table 2. — Patient Diagnoses

Diagnoses	Number
Cerebrovascular accident	86
Depression/Confusion	81
Urinary incontinence	72
Hypertension	70
Arthritis	69
Diabetes	62
Coronary artery disease	53
Chronic obstructive pulmonary disease	46
Decubitus	35
Para or quadriplegia	32
Malnutrition	26
Anemia	23
Morbid obesity	20
Amputee — lower extremity	15
Parkinson's disease	15
Carcinoma	15
Myocardial infarction — recent	14
Contractures	11
Cataracts	11
Fractured hip	11
Chronic renal failure	10
Hypothyroidism	7
Asthma	5
Burns	5
Heavy metal [Pb-AS]	4
Head trauma	3
Dermatomyositis	3
Zinc & thiamine deficiency (gastric stapling)	3
Sleep apnea	3
Neurosyphilis	2
Miscellaneous	29

evaluate the need for and availability of social support from both family and environment. A dietitian determines dietary needs and preferences and evaluates the capacity of the patient and the patient's family to plan menus compatible with those needs. A case manager is designated to orient the patient and family to the institute and its programs, arrange family conferences, and arrange for care after the patient is discharged. Specialists in speech, audiology, hand therapy, and dental hygiene assess the patient's speech, manual dexterity, and dentition.

After the assessment and evaluation period, the team meets and a decision is made, with patient and family input, as to whether the patient is a rehabilitation candidate. If not, other care or placement arrangements are made. Patients chosen for rehabilitation remain in the O'Donoghue Rehabilitation Institute for intensive rehabilitation until a plateau is reached or until the initial or modified goals are met. Independent living capability is strengthened in some patients, either in a single apartment or the institute's family unit. At the end of each year, the patients receive a questionnaire to fill out; the pa-



tients are then reevaluated to determine both their status and the effectiveness of the program.

### Admission Characteristics

The admission data for the first 200 patients are shown in Table 1. The typical patient, 62 years of age, is being discharged from an acute care hospital. Prior to admission to the acute care facility, 40% of these patients were living in their own homes with their spouses. Twenty-five percent were widowed or divorced and living alone in their own homes. Twenty-four percent were living with family members. Twenty-one percent of the patients came from the Veterans Administration Medical Center. Ten percent were admitted from nursing homes; however, 18% of all the patients had been scheduled for admission to nursing homes. Eighty-seven percent were confined to a bed or wheelchair or required constant assistance with walking. Thirty-six percent had urinary incontinence or had Foley catheters in place. Only 2% had primary caretakers, other than the aforementioned, living with them. Family support was excellent for most of the patients. For less than 20% of the patients, the families were rarely involved. The vast majority of referrals were from the physicians caring for the patients.

The average number of diagnosed illnesses per patient on admission was 4.25. Twenty-eight percent were either scheduled for admission to or had come from a nursing home. Table 2 demonstrates the distribution of diagnoses on admission. Forty-three percent of the patients presented with cerebrovascular accidents as their major problem. However, the vast majority of patients had multiple medical problems that resulted in functional disabilities requiring admission.

### Characteristics at Discharge

Of the 200 patients admitted, three died while in the rehabilitation unit (Table 3). The major indicators of the success of the rehabilitation unit, given our stated objective of improving the quality of life, are place of residence and amount of care required at discharge. At the time of discharge, 7.5% of the patients went to nursing homes. Twenty-eight percent were either wheelchair bound, bedfast, or needed constant assistance with walking and self-care (Table 4). Only 8 patients were bedfast, while the remaining 48 patients used a wheelchair to move about. Only 2% were discharged with indwelling or external urinary catheters. The average length of stay in the rehabilitation institute was 38 days.

The results of the questionnaire and annual reevaluation of the patients revealed two major points: (1) the vast majority of patients either con-

Table 3. — Discharge Data

Discharge Characteristics	Number	Percent
Admissions	200	
Discharges	197	
Discharged with Foley or external catheter	4	(2.0%)
Confined to bed	8	(4.0%)
Needed constant assistance	6	(3.0%)
Confined to wheelchair	42	(21.0%)
Discharged to nursing home	15	(7.5%)
Average length of stay	38 days	
	(Range 2-66)	

tinued to progress or at least did not deteriorate after discharge, and (2) twenty percent were apparently discharged too early, as 40 patients were subsequently readmitted to the O'Donoghue Rehabilitation Institute or another rehabilitation unit and subsequently achieved moderate to marked improvement in their walking and/or self-care abilities.

### Discussion

The data presented compare quite favorably with data reported from other units involved in the rehabilitation of chronically ill and elderly patients.<sup>6,7</sup> As implied in our stated objectives, the patients in this review were considered to be at high risk for institutionalization. They had striking impairments in levels of function (87.5% needed constant assistance for walking or could not walk at all), 36.0% had urinary incontinence or had Foley catheters in place and had multiple medical problems. With these initial levels of impairment, it is encouraging that on discharge, only 7.5% of the patients were placed in nursing homes, 24.0% required assistance with walking or could not walk at all (only 4.0% were confined to bed), and 2.0% were discharged with external or Foley catheters in place.

Although the vast majority of our patients continued to improve or remained stable in their ability to move about and care for themselves after discharge, it became apparent to us, based on the year end reassessment and evaluation, that 20% of our patients were discharged from the unit prematurely.

A descriptive study like this, with no comparison group, does not prove cause and effect. However, when one reviews both anecdotal reports, which indicate that very few persons sent to nursing homes for "convalescence" ever return to the community, and well controlled studies, which demonstrate that the structure of a chronic illness and geriatric rehabilitation unit is more conducive to maximum functional improvement, these data are encouraging. Acute-care hospitals focus on the patient's presenting illnesses tending to ignore functional status and offering little

Table 4. — Mobility Characteristics: Admission vs Discharge

	Admission	%	Discharge	%
Total number of patients	200		197	
Confined to bed, wheelchair, or needing constant assistance with ambulation	175	(87.5%)	58	(29.0%)
Urinary incontinence	72	(36.0%)	4	(2.0%)
Foley or external urinary catheters	28	(14.0%)	4	(2.0%)
Number of patients from nursing home or scheduled for nursing home placement	56	(28.0%)	15	(7.5%)

ehabilitation.<sup>2,9</sup> In addition, in acute-care hospitals here is little opportunity for health care personnel to communicate with one another regarding the patient's problems or improvements, and relatively little time or effort is spent on maximizing the patient's functional status.<sup>9</sup>

Even though randomized controlled studies are needed to clarify cause and effect, the positive outcome in terms of patient function and disposition shown in this report and in other cited data strongly suggest that a rehabilitation unit for the chronically ill and aged may prevent institutionalization and improve the quality of life for many functionally impaired people. □

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# A Study of 138 Return Service Scholarship Applications

Awarded by the  
Oklahoma Physician Manpower Training Commission

JUNE E. HOLMES, EDD, and DEBORAH A. MILLER, MS\*

**The results of the analyses of 138 Oklahoma Scholarship applications showed a marked difference between those recipients who met their obligations in service and those who elected to pay back their loans in dollars. The population of the chosen practice site was a significant factor, with those who paid back in dollars establishing their practices in the larger communities. Based on an analysis of 86 statements as to interest in rural practice, "having been brought up in such a community" and "preference for urban or rural living" were among those more frequently stated by the service payback group.**

**T**he Physician Manpower Training Commission (PMTTC) was created in 1975 to increase the number of practicing physicians in underserved and rural areas. The commission administers four programs: the Oklahoma Rural Medical Education program, the Community Physician Education Scholarship program, Internship-Residency Cost-Sharing Program, and Physician Placement Program.

A high-priority objective of the PMTC is to assist Oklahoma communities in selecting and financing qualified osteopathic and medical students to participate in the Community Physician Education Scholarship Program. Application for these scholarships is

made during medical school years and, if granted, monies are given on a monthly basis. In accepting the scholarship, the student makes a return service agreement whereby if the recipient changes his/her mind and chooses not to engage in such a practice, he/she is relieved of the obligation by repayment of the loan plus interest and penalties.

Since its inception, a total of 138 scholarship recipients have completed medical school and postgraduate training. Practice locations of the scholarship recipients is monitored by the Commission.

## Methods

A total of 138 records of scholarship applications were used as the data collection source. The following seven areas of information were included for analysis:

1. Amounts of dollars borrowed.
2. Population of high school town.
3. Population of postgraduate training site.
4. Population of practice site upon graduation.
5. Community Match Scholarship recipient.
6. Rural Scholarship recipient.
7. MD or DO identities.

Means and standard deviations were computed for each of these variables. A "t-test" was used to determine the significance of differences between means. Responses related to interest in rural practice provided an additional data source. One hundred ninety-seven statements were grouped using factors identified by the National Health Service Corps (1983).

This paper was presented in part to the Physician Manpower Training Commission reporting the practice location decisions of state-supported medical scholarship recipients.

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**Appendix A**  
**Comparisons for Scholarship Recipients**  
**Service and Payback Groups**

Scholarship	Amount Borrowed				Population of High School Community				Population of Postgrad Training Site				Population of Practice Site			
	N	Mean	SD	T-Test	N	Mean	SD	T-Test	N	Mean	SD	T-Test	N	Mean	SD	T-Test
<b>Rural</b>																
Service	58	14941	4136	-2.17**	57	78650	160153	ns	56	316882	407047	ns	58	4335	2601	-5.59***
Payback	25	17057	3902		23	83179	139717		25	300896	272928		25	87944	114749	
<b>Community</b>																
Service	36	18973	6922	ns	35	58911	112027	ns	36	322939	284783	ns	36	3631	2113	-6.40***
Payback	19	19257	8323		18	56374	114940		19	295688	150823		18	171393	158798	
<b>High School Population</b>																
Service	76	16553	5775	ns	76	11929	18371	ns	75	326080	392241	ns	75	4048	2365	-7.16***
Payback	34	18092	5525		34	13172	17877		34	297694	248815		34	119978	140896	
<b>Osteopath</b>																
Service	62	16149	5383	ns	61	88183	162020	ns	61	292854	252747	ns	62	3997	2244	-6.73***
Payback	5	16140	5422		5	150414	172168		5	329660	158991		4	117610	150896	
<b>Medicine</b>																
Service	32	17137	6276	ns	31	37605	90844	ns	31	371196	513560	ns	32	4199	2802	-4.81***
Payback	39	18247	6370		36	60438	119057		39	294671	235499		39	123417	140033	
<b>Type of Practice</b>																
General/Family	112	16657	5704	ns	110	74184	145273	ns	111	301523	357310	ns	112	24552	66944	-4.85***
Specialists	25	18272	6907		22	59650	111460		25	361704	103177		24	121482	155949	
<b>Total Recipients</b>																
Service	94	16485	5722	ns	92	71140	144075	ns	92	319252	364139	ns	94	4066	2450	-8.20***
Payback	44	18007	6305		41	71411	130106		44	298647	228371		43	122876	141089	

\*\*\*Significant at .001 level  
 \*\* Significant at .05 level

## Results

Ninety-four students (68%) met their scholarship obligations through service, while 44 students (32%) paid back in dollars. To determine which factors may have influenced the students' practice decisions, several comparisons were made. Significant findings for the seven areas are as follows:

**1. Amounts of dollars borrowed.** In a comparison of the amounts of dollars borrowed by rural schol-

arship recipients, the payback group borrowed significantly greater (-2.17) amounts than the service group (Appendix A). When the amounts borrowed were examined among community, osteopathic, medical, and total recipients, no significant differences were noted.

In a comparison of rural scholarship recipients before and after 1976, the year the PMTC became involved, it was noted that the post-1976 recipients

**Table 1.—High School Community Size & Practice Size Among Service & Payback Groups**

Population	Service				Payback			
	High School Size		Practice Size		High School Size		Practice Size	
0-2,500	31	34%	34	36%	9	22%	0	0%
2,501-10,000	30	33%	60	64%	12	29%	.5	12%
10,001-25,000	5	5%	0	0%	5	12%	6	14%
25,001-100,000	10	11%	0	0%	8	20%	19	44%
100,000 +	16	17%	0	0%	7	17%	13	30%
Total	92	100%	94	100%	41	100%	43	100%



Appendix B  
Comparisons for  
Rural Scholarship Recipients  
Pre & Post 1976

Scholarship	Amount Borrowed				Population of High School Community				Population of Postgrad Training Site				Population of Practice Site			
	N	Mean	SD	T-Test	N	Mean	SD	T-Test	N	Mean	SD	T-Test	N	Mean	SD	T-Test
<b>Rural (Pre-76)</b>																
Service	18	14905	4471	ns	17	64314	202233	ns	16	486190	686776	ns	18	4946	2688	-3.14***
Payback	10	15204	3290		8	6504	6336		10	314860	166911		10	86221	111330	
<b>Rural (Post-76)</b>																
Service	40	14957	3975	-2.81**	40	84743	137999	ns	40	249158	165062	ns	40	4060	2513	-4.67***
Payback	15	18293	3788		15	124073	158438		15	291587	324593		15	89093	116959	
<b>Service</b>																
Pre 1976	18	14905	4471	ns	17	64314	202233	ns	16	486190	686776	ns	18	4946	2688	ns
Post 1976	40	14957	3975		40	84743	137999		40	249158	165062		40	4060	2513	
<b>Payback</b>																
Pre 1976	10	15204	3290	-2.10*	8	6504	6336	-2.08*	10	314860	166911	ns	10	86221	111330	ns
Post 1976	15	18293	3788		15	124073	158438		15	291587	324593		15	89093	116959	
<b>Total Recipients</b>																
Pre 1976	28	15012	4092	ns	25	45815	168970	ns	26	420294	554902	ns	28	33973	77122	ns
Post 1976	55	15867	4196		55	95469	144924		55	260730	221148		55	27251	71899	

\*\*\*Significant at .001 level  
\*\*Significant at .05 level  
\*Significant at .01 level

borrowed a significantly greater (-2.10) amount than the pre-1976 recipients (Appendix B). Among the post-1976 recipients, the payback group borrowed significantly more (-2.81) than the service group.

**2. Population of high school community.** The size of the community that one grew up in has been identified in previous studies as a contributing factor in differentiating those who establish rural practices from those who elect nonrural practice settings.

Table 1 identifies by population density the high school community population and practice site population for the service and payback groups. In the service group, 61 applicants (67%) attended high school in towns with populations of 10,000 or less. One

hundred percent of these applicants established practice in towns of this same size category.

In the payback group, 51% went to high school in communities with populations of 10,000 or less. However, only 12% of this group returned to a community of this size. Conversely, 37% of these students were from communities with populations of 25,000 or more, with 74% choosing to return to communities of 25,000 or more. T-test results showed that, in relation to the size of their high school communities, there was no significant difference between those students who met their service commitments and those who paid back in dollars.

Further analysis compared the two groups from

Table 2.—Practice Size Locations—General/Family Practice and Specialties Service and Payback Groups

Community Size	Service				Payback			
	GP/FP	%	Spec	%	GP/FP	%	Spec	%
0-2,500	31	35%	0	0%	0	0%	0	0%
2,501-10,000	57	65%	5	100%	2	8%	3	16%
10,001-25,000	0	0%	0	0%	5	21%	1	5%
25,001-100,000	0	0%	0	0%	11	46%	8	42%
100,000+	0	0%	0	0%	6	25%	7	37%
Total	88	100%	5	100%	24	100%	19	100%

**Appendix C  
Specialty Choices**

	N
Anesthesiology	1
Emergency Medicine	3
Internal Medicine	4
Neurology	1
Ob/Gyn	3
Ophthalmology	1
Orthopedic Surgery	1
Pathology	1
Pediatrics	2
Pulmonary	1
Radiology	3
Surgery	4
Total	25

high school community sizes of less than 100,000. There were no significant differences for rural and community scholarships, medical identities, and total recipients for the high school community size.

High school community size was significant ( $-2.08$ ) when payback recipients of pre-1976 rural scholarships were compared with payback recipients of post-1976 scholarships (Appendix B). The 15 students (65%) receiving scholarships after 1976 came from markedly larger high school communities.

**3. Postgraduate training site size.** No significant differences were noted in this area.

**4. Practice site size.** The population of the practice site indicates a statistically significant difference ( $-8.20$ ) for those in the payback group and those in the service group. It is readily noted that those recipients who established their practices in the larger communities elected the "payback option." Significant findings were also noted when the data were analyzed to determine if there were any relationships between the service and payback groups if the recipients were under the Rural Scholarship or Community Match Program; enrolled in Osteopathic or Medical Programs; from large or small high schools; and, engaged in Primary or Specialty practice (Appendix A).

The results of the different analyses clearly dem-

onstrate that the conditions under which the scholarships are awarded, that is, to set up practice in a rural or specific community, will be complied with when the time comes to choose a practice site. It appears that the larger the practice community, the more likely the recipient will choose the "payback option" which is within the guidelines set by PMTC.

Table 2 supports the finding that within the service group, physicians, whether general/family practitioners or specialists, located in communities of less than 10,000. However, in the payback group, 22 (92%) general/family practice physicians and 16 (84%) of specialists located in community sizes of 10,000 or more. Of the total general/family practice group, 24 (21%) opted for payback while 19 (79%) of the specialists group did the same.

**5. Community match scholarship recipients.** No significant differences were noted in this area.

**6. Statements of intent in rural practice.** Each applicant had the opportunity to state his/her reasons for desiring to locate in a rural setting. A total of 86 (62%) applications had one or more statements which were tabulated according to frequency as follows:

A. Having been brought up in such a community	43
B. Preference for urban or rural living	38
C. High medical need in the area	37
D. Influence of spouse	22
E. Desire to raise family in rural setting	17
F. Influence of family or friends	10
G. Opportunities for social life	8
H. Quality of education system for children	4
I. Advice of older physician	4
J. Climate or geographic features of area	4
K. Opportunity to join partnership	3
L. Previous medically related occupation in community	3
M. Forgiveness of educational loan in exchange for service	2

**Table 3.—Application Statements of Service and Payback Groups**

Statements	Service		Payback		Total
	N	%	N	%	N
Having been brought up in such a community	36	82%	7	18%	43
Preference for urban or rural living	35	92%	3	8%	38
High medical need	31	83%	6	17%	37
Influence of spouse	19	86%	3	14%	22
Desire to raise family in rural setting	13	77%	4	23%	17



N. Having gone through medical school/residency in area	2
Total	197

Further analysis was made according to service and payback groups. Table 3 identifies the five statements that appeared most frequently within both groups. More than 75% of the service applications contained at least one of the five statements.

### Summary

As a result of this study, it is our conclusion that the variables used prior to actual scholarship awards cannot be used to identify or predict those individuals who will later meet their obligation. At the time the student applies for the loan, his or her intent to comply with the commitment may be impossible to ascertain. Both the medical education and personal goals of the students may have an impact on the final practice location choice. The analysis of the 86 statements as to interest in rural practice do support the continuation of having applicants complete this section, as these statements appear to be more predictive of fulfillment of the return service agreement. Analysis of high school community population sizes in this study did not support past findings indicating that this variable could be used as a predictor. However, among those applicants who made reference to being brought up in a similar community, a majority established practice in smaller communities. □

**Acknowledgement:** We acknowledge the assistance of the Physician Manpower Training Commission, and are especially grateful to Darla Puckett and Cindy Carter for preparation of the manuscript.

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## Coming in November . . .

Among the papers being reviewed for publication next month are a case report on botulism, a discussion of home care for ventilator-dependent children, and a study of petitions for court commitment to psychiatric care in Tulsa County.

Already scheduled is "Hypertension II: Statistical Correlation of Seventy-eight Diet Components to Blood Pressure."



## Evaluation of Supplemental Feeding Program for Women, Infants, and Children (WIC)

A US Department of Agriculture-sponsored evaluation of the Special Supplemental Feeding Program for Women, Infants, and Children (WIC), confirms that participation in the program increases those women's chances of having a healthy baby.

The study in which LeFlore, Custer, Beckham, and Kiowa counties participated shows that WIC participation results in increased birth weights of newborns.

The findings also show that participation in WIC causes more women to seek early prenatal care, a critical factor for a successful pregnancy. These women also had longer gestation periods. Infants born to WIC women had average head circumferences greater than infants born to non-WIC women.

In addition, the study shows WIC participation was associated with better cognitive performance.

Children four and five years old whose mothers participated in WIC during pregnancy had significantly better vocabulary scores. Children one year of age and older who first received WIC had better digit memory.

Infants participating in WIC had significantly increased intakes of iron and vitamin C.

Implemented in Oklahoma in 1976, WIC is available through 67 county health departments for low-income pregnant and breastfeeding women, and infants and children up to five years of age who are nutritionally at-risk. The program serves approximately 36,000 Oklahomans each month.

The Oklahoma State Department of Health believes WIC introduces clients to health care opportunities they may not have known were available and helps make regular care part of their lives. □

DISEASE	July 1985	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	2	9	6	12
CAMPYLOBACTER INFECTIONS	41	183	120	—
ENCEPHALITIS, INFECTIOUS	5	19	16	14
GIARDIA INFECTIONS	29	137	118	—
GONORRHEA (Use ODH Form 22B)	1249	7137	7196	8384
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	8	130	115	—
HEPATITIS A	18	284	251	274
HEPATITIS B	8	117	100	145
HEPATITIS, NON-A NON-B	2	41	30	—
HEPATITIS UNSPECIFIED	5	45	69	117
MEASLES (RUBEOLA)	1	1	8	156
MENINGITIS, ASEPTIC	10	56	46	77
MENINGITIS, BACTERIAL				
(non-meningococcal, non H. Influenzae)	3	43	30	34
MENINGOCOCCAL INFECTIONS	0	19	23	23
PERTUSSIS	0	80	207	71
RABIES (Animal)	6	72	75	120
ROCKY MOUNTAIN				
SPOTTED FEVER	2	46	94	89
RUBELLA	0	1	0	1
SALMONELLA INFECTIONS	35	186	223	207
SHIGELLA INFECTIONS	20	119	109	151
SYPHILIS (Use ODH Form 22B)	11	112	112	107
TETANUS	0	0	1	0
TUBERCULOSIS	14	147	138	178
TULAREMIA	1	7	14	15
TYPHOID FEVER	0	0	2	2

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	4
BRUCELLOSIS	4
LEGIONNAIRES DISEASE	7
MALARIA	2
REYE SYNDROME	2
TOXIC SHOCK SYNDROME	9
RABIES	
BECKHAM	Skunk 1
MUSKOGEE	Skunk 1
PITTSBURG	Skunk 1
ROGERS	Bat 1
ROGER MILLS	Skunk 1
STEPHENS	Coyote 1



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## MAPS from AMA to aid in selection of practice sites

The American Medical Association (AMA) has announced a new activity that will aid a physician in developing or modifying a medical practice. The AMA Market Area Profile (MAP) Service, created as a part of the association's Competition Action Plan, is designed to assist physicians in establishing and maintaining a successful medical practice by providing them with detailed demographic and health resource data on an existing or planned practice site.

The MAP Service offers physicians individualized, computer-generated data profiles on any area in the United States. Each Market Area Profile consists of six data reports:

(1) *The Area Profile Report* — 1980 census data (eg, population, age, sex, housing, occupation, income, etc) for the area that the physician has selected.

(2) *The State Area Profile Report* — 1980 census data for the state in which the physician-selected area is located, provided for comparison purposes.

(3) *The Demographic Trends Report* — 1980, current year, and five-year projected population and demographic data (eg, population, age, sex, household size, etc).

(4) *The State Demographic Trends Report* — A trends report for the state in which the selected area is located, provided for comparison purposes.

(5) *The Physician Report* — Statistical information on the number of physicians in the area, by medical specialty, age, and major professional activity.

(6) *The Hospital Report* — Detailed information on hospitals in the selected area, including number of beds; admissions, utilization, and census figures; facilities and services; and a profile of the medical staff. (If there are more than four hospitals in the selected area, a summary listing of the hospitals is provided instead.)

The information provided in a MAP profile can be beneficial to all physicians, no matter what their practice situation. New physicians may find it helpful

in practice site selection decisions, whether they are investigating specific practice opportunities or comparing several practice sites. Established physicians can use the profiles to make decisions about expanding, relocating, or modifying an existing practice. For example, a physician might wish to use the MAP demographic reports to compare his current patient base with the potential patient population of the community. Another physician might want to study the five-year projected population figures as part of the development of a long-range practice plan. In any event, the Market Area Profile Service is a planning tool that can help physicians make decisions about their practices.

A key feature of the MAP Service is the flexibility offered to the physician subscriber in selecting the area to be profiled. There are four choices: (1) county, (2) ZIP code, (3) city/town, and (4) ring study. The ring study option is a unique aspect of the MAP Service that allows the physician to precisely define the area of study in relation to an existing or planned office site. Using a specific street intersection as the center point, the physician can define the area as a ring of *any size* (for example, five or ten miles) around that intersection. This may be useful in instances where a standard geographic description does not adequately describe a physician's service area.

The cost of the Market Area Profile Service ranges from \$95 to \$195, with substantial discounts for AMA members, medical students, and residents. Along with the six profile reports, physicians receive a User's Manual that provides data source information and offers useful advice on how to interpret and apply the data to practice situation.

For further information, and to receive the MAP Registration Package, please contact the AMA Market Area Profile Service, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610, (312) 645-4719. □



## Study examines factors in the success of female physicians

Career achievement among women physicians is influenced less by marriage and family size than by motivation and personal factors shaped in early life.

Pirkko Lauslahti Graves, PhD, and Caroline Be-  
dell Thomas, MD, of Johns Hopkins University  
School of Medicine, Baltimore, examined factors con-  
tributing to midlife career achievement among 108  
Johns Hopkins women physician graduates. All had  
graduated between 1948 and 1964; most were be-  
tween 50 and 59 years of age. The study included 37  
academic physicians whose career achievements in-  
cluded teaching, practice, and research; 34 clinical  
board-certified physicians whose careers centered  
around the practice of medicine; and 37 physicians  
with more circumscribed careers (all but two had  
gained residency training, none was board certified,

and none had university affiliations).

Several early factors were associated with midlife  
career achievement, the researchers say in the *Jour-  
nal of the American Medical Association*. Among  
them were academic standing, father's socioeconomic  
status, and family (specifically father-daughter) re-  
lationships.

Academic standings, based on grade point average  
in medical school, revealed striking differences  
among groups even though overall averages were  
high, with almost half of the women in the upper  
third of their classes. Women in the academic career  
group had significantly higher standings than those  
in the circumscribed group, and clinical physicians  
ranked intermediate. A further breakdown within  
the academic group showed additional stratification:  
full professors were more likely to be in the top third  
of their classes than associate or assistant professors.

"The significant association between academic  
standing in medical school and career achievement  
at midlife merits particular attention in light of fre-  
quent reports that grades poorly predict physicians'  
career performance," the researchers say.

The study showed that fathers of women in the  
circumscribed group had the highest socioeconomic  
status. The researchers suggest that perhaps the  
women from families of lower socioeconomic standing  
felt more need to elevate their status through their  
medical career. They also found that women in the  
academic group reported the worst family relation-  
ships and were most likely to describe relationships  
with their fathers as distant or unsatisfactory. The  
study found no correlation between birth order and  
midlife achievement.

The majority of women in all three groups were  
married (84% were or had been married; 27% were  
separated, divorced, or remarried). The women had  
an overall average of 2.6 children each, and no differ-  
ences in family size were noted between groups.  
There were more women in the academic group who  
had never married, and fewer full professors married  
as compared with associate professors or assistant  
professors (57%, 64%, and 81%, respectively). Among  
the married women, however, full professors had the  
largest families (mean number of children 4.3, com-  
pared with 2.4 among associate professors and 2.1  
among assistant professors).

"These findings suggest that the relationship be-  
tween family and career is complex and raises the  
need to explore other mediating factors that enable  
some women to combine career and family roles while  
other women fail to do so or do so less successfully,"  
the researchers say. □

## Commercial hair analysis proves unreliable as diagnostic tool

Commercial hair analysis used to detect the body's  
need for certain nutrients is little more than a scam,  
according to a recent study.

Stephen Barrett, MD, of Allentown, Pa, reports  
that hair samples from two healthy 17-year-old girls  
were sent to thirteen different laboratories under as-  
sumed names. "The reported levels of most minerals  
varied considerably between identical samples sent  
to the same laboratory and from laboratory to labora-  
tory," Barrett says in the *Journal of the American  
Medical Association*. He adds that laboratories dis-  
agreed about normal and abnormal levels of miner-  
als, and many provided lengthy computer-generated  
reports that contained potentially frightening health  
interpretations. Six of the laboratories recommended  
nutritional supplements, but the types and amounts  
varied widely among reports from the same labora-  
tory and between laboratories.

"Even if hair analysis were a valuable diagnostic  
tool, it appears that most, if not all, of these  
laboratories are unreliable," Barrett says. "For most  
minerals, several laboratories reported values at  
least ten times those reported by other laboratories."

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## OSMA Board of Trustees mixes business & pleasure in August

Rick Ernest (far left), deputy executive director of the OSMA, receives a plaque of appreciation from OSMA President Elvin M. Amen, MD. Ernest, after serving the OSMA for almost nine years, was recently named executive director of the Oklahoma County Medical Society.

Below, a more sober mood prevails as Ray Cornelison, MD, (standing) OSMA secretary-treasurer, presents the financial report.



## Attention Medical Students

The JOURNAL of the Oklahoma State Medical Association announces its annual competition for the best scientific paper submitted by an Oklahoma medical student and published in the JOURNAL. The \$100 cash prize is presented at the OSMA's Annual Meeting in May.



OSMA Executive Director David Bickham (right) enjoys the shade of the front portico with OSMA President-Elect Norman L. Dunitz, MD.



## Picnic in OKC draws large crowd

Elvin M. Amen, MD, OSMA president, had a chance to meet many of the students individually. Here he talks with Stig Peitersen.





**Mary Ann Deen, president of the OSMA Auxiliary, shares a picnic table with Rick Ernest, OSMA deputy executive director.**



The Fourth Annual OSMA Student Picnic was held August 23 on the grounds at OSMA headquarters in Oklahoma City.

A crowd of nearly 300 first-year medical students, spouses, children, physicians, and OSMA staff members was on hand for the occasion. OSMA Deputy Executive Director Rick Ernest delivered the invocation and President Elvin M. Amen, MD, spoke briefly to the students about their chosen profession.

The students were welcomed to the Oklahoma medical community with a dinner of fried chicken, baked beans, and potato salad. In the late afternoon heat, cold drinks were much in demand despite some last-minute cloud cover.

The annual picnic is part of a continuing effort to bridge the communication gap between medical students and organized medicine.

**Paula Camp, chairperson of the OSMA Student Section, introduces OSMA President Elvin Amen, MD.**





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# FDA likely to approve use of irradiation in food processing

The Food and Drug Administration is likely to approve food irradiation for a variety of purposes later this year. Whether consumers will also approve of this new technique remains uncertain

Irradiation (the treatment of foods with ionizing radiations such as gamma rays) has been shown to be safe in a systematic, comprehensive scientific testing program, according to the report "Irradiated Foods," published by the American Council on Science and Health (ACSH), an independent scientific organization.

Irradiation has a wide variety of uses, the report states. Among them are destruction of microorganisms in food to produce shelf-stable products similar to canned foods; inactivation of *Trichinella spiralis* (the causative agent of trichinosis) in fresh raw pork; destruction of insects in foods; inhibition of the sprouting of potatoes, onions, and garlic; and delaying the ripening of noncitrus tropical fruits.

"Irradiation has been subjected to extensive

safety testing, and scientists and international health authorities are now convinced that foods processed in this way do not pose a health hazard. In some cases, they may even have health advantages. For instance, irradiation can be used to kill the food poisoning organisms, such as *Salmonella*, that are often found on raw meat and poultry," according to the report.

"Many consumers are very concerned about food irradiation, but I think they would be reassured if they were more thoroughly informed about the process," notes one of the authors. "For instance, some people think that irradiated foods might be radioactive. But in fact, the types and levels of radiation used to treat foods cannot induce radioactivity."

To obtain a complimentary copy of "Irradiated Foods," send a self-addressed, stamped (39¢ postage), business-size (#10) envelope to Irradiated Foods Report, ACSH, 47 Maple St, Summit, NJ 07901. □

# NIH panel looks at dentists' use of general anesthesia

Risks associated with the use of general anesthesia in the dental office are on the order of one death per every 350,000 to 860,000 administrations of anesthetic, according to a National Institutes of Health (NIH) consensus conference report.

"Data concerning morbidity are extremely limited and do not permit the calculation of rates," the report states. "A general impression suggests that an increased morbidity and mortality are associated with greater duration of anesthesia and complexity of the dental procedure."

The NIH convened a consensus conference to address a number of questions posed regarding training needed for safe and effective use of sedation and general anesthesia. "Pain is a major factor that brings patients to the dental office, while fear and anxiety about pain are common reasons patients fail to seek dental care," the report notes.

"The magnitude of this public health problem is indicated by the fact that there are 35 million Americans who avoid dental treatment until forced into the office with a toothache. The control of pain and anxiety is therefore an essential part of dental practice."

Among the issues considered by the panel were the indications and contraindications for use of general anesthesia and sedation in children, adults, and the elderly; appropriate agents and techniques for general anesthesia and sedation; facilities, equip-

ment, personnel, and training needed; and risks.

"The use of all effective drugs carries some degree of risk, however small," the report concludes. "Available evidence suggests that use of sedative and anesthetic drugs in the dental office by appropriately trained professionals has a remarkable record of safety. However, even this record can be improved as scientific knowledge of dental anxiety and pain control is expanded, as strong training programs at all levels of professional education are developed, and as appropriate guidelines governing requirements for dental office personnel, facilities, and equipment are promulgated and adopted."

In a related article, William E. May, MD, of Macon, Ga, points out that consensus conference opinions should be treated as provisional rather than definitive. "Consensus can shape behavior through illumination without stifling thought through authoritarian control," he says.

Commenting on the consensus process itself, Fitzhugh Mullan, MD, of the New Mexico Department of Health in Santa Fe, and Itzhak Jacoby, PhD, of the NIH in Bethesda, Md, point out that it is now more than seven years old. "As a technology assessment process, consensus conferences have evolved and matured considerably since their early days," they say. Now the conference reports are more uniform, useful, and consistent. □



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# Childhood obesity offers clue to atherosclerosis in adults

Susceptibility to heart attack can be detected in children as young as 12 years of age, suggests a new study. Researchers from Louisiana State University Medical Center in New Orleans tracked 1,598 youngsters from ages 5 to 12 and found that increases in obesity in youth are accompanied by an increasingly atherogenic lipoprotein profile.

Measured were increases in triceps skin-fold thickness, the muscle and flesh directly below the biceps in the arm, in relation to changes in total blood cholesterol, blood triglycerides, and low- and very low-density lipoprotein cholesterol, elevations of which are associated with increased risk of heart disease. Findings demonstrated "significant positive correlations" between increases in triceps thickness and elevations in blood lipids associated with heart disease.

"Although females showed the largest increases in triceps skin-fold thickness, most associations were stronger in males," report David S. Freedman, PhD,

and colleagues in the *Journal of the American Medical Association*.

"Obesity-related changes in serum lipids and lipoprotein levels during childhood may play a role in the initiation of atherosclerosis," they observe. "In adolescents and young adults, total cholesterol and low-density lipoprotein cholesterol levels are strongly related to aortic fatty streaks, and very low-density lipoprotein levels are associated with fatty streaks in the coronary arteries."

They point out that intervention programs among adults demonstrate a positive association between weight loss and reduction of heart disease risks, measured by changes in blood lipids. "Since the effects of weight loss on cardiovascular disease risk factors may be greater in younger than in older individuals, effective cardiovascular disease intervention should focus on prevention of excessive weight gain in childhood and adolescence, the researchers conclude. □



## PLICO loss prevention seminars play to packed houses this fall

A series of loss prevention seminars presented by the Physicians Liability Insurance Company (PLICO) has been drawing capacity crowds this fall. Speakers have included Oklahoma City attorney Robert Margo (far left) of Short, Barnes, Wiggins, Margo and Adler, and Ellison C. Pierce, MD, (near left) chairman of the Department of Anesthesia at Harvard Medical School's Deaconess Hospital. In the audience are OSMA President Elvin M. Amen, MD, (center, white jacket) and, to his right, Rod Frates, president of C. L. Frates and Company, who was also a speaker.





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## Tendencies to depression and suicide seem to be inherited

Predisposition for severe depression and suicide may be passed from one generation to the next, according to a study of the Amish.

Janice A. Egeland, PhD, and James N. Sussex, MD, of the University of Miami School of Medicine studied the incidence and circumstances of suicides that occurred during a 100-year period in a community of Old Order Amish living in southeastern Pennsylvania. Because marriage occurred within the community and because the Amish way of life does not have the economic and social stresses often associated with suicide, this population provided an opportunity to evaluate possible genetic factors.

The findings, reported in the *Journal of the American Medical Association*, were striking: "The suicides clustered in four primary pedigrees, and the role of inheritance was suggested by the way in which suicides followed the distribution of affective disorders in these kinship lines," the researchers say. The majority (92%) of the 26 suicides occurred in persons diagnosed with major affective disorders, and they occurred in families with higher incidence of depression, manic depression, and other affective disorders. The researchers conclude that appropriate intervention and treatment for these disorders is especially warranted in patients with a positive family history.

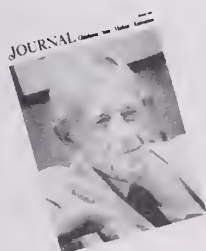
By interviewing family members, affective disorders were diagnosed for all but one of the suicide cases: there were 12 bipolar (manic depressive) cases, 12 unipolar (severe depression) disorders, one un-



Jodie Edge, MD, Norman, and Lanny Trotter, MD, Stillwater, work side by side at the August meeting of the OSMA Board of Trustees. However, with the football season now in full swing, they may choose opposite sides of the table in November.

specified psychiatric disorder, and one case of minor depression. Except for the person with minor depression, the families of all suicide victims also showed increased incidence of affective disorders, the researchers note. Every person with bipolar disorder who committed suicide had first- or second-degree relatives with bipolar and unipolar disorders.

Of the 26 suicide victims, 21 were men and 5 were women; the mean age for men was 41 years and for women, 55 years. The age range for men was 18 to 69 years, with most of the suicides occurring during the middle years; the age range for women was 42 to 72 years. The majority of the victims were married and had children; one woman and four men were single. Only six had received any psychiatric care; the other 20 had either received no treatment, were seeing a family doctor, or were "planning to do something." □



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## Mitsubishi plans test of AMA/NET among Japanese doctors

AMA/NET data bases will be field tested in Japan by Mitsubishi Corporation to determine the utility of the English-language medical information network for Japanese physicians, according to a July 25, 1985, agreement by James H. Sammons, MD, executive vice president of the American Medical Association (AMA), and Mitsubishi Corporation's Managing Director Yoshio Taniguchi. The link-up, with 100 Japanese physicians and hospitals, is to begin this month and is slated to end in mid-1986.

"AMA/NET has yet to undergo such extensive international testing," said Dr Sammons. "The AMA is pleased that its data bases were selected for this unique research project."

"We are confident the AMA's data bases will contribute greatly to the quality of medical information available in Japan," Mr Taniguchi said. "We look forward to providing this key link between the United States and Japan."

AMA/NET data bases are part of the GTE Telenet Medical Information Network. They include Disease Information, Drug Evaluations and its companion Drug Therapy; Socioeconomic Information (a litera-

ture search); EMPIRES (a clinical literature search), Medical Procedure Coding and Nomenclature, a series of continuing medical education courses from Massachusetts General Hospital, and the Associated Press Medical News Service.

Mitsubishi Corp., through its subsidiary AMS Corp., plans to evaluate the market potential of the data bases to see whether Japanese physicians will be able to overcome the language barrier sufficiently to benefit from the information.

Dr H. Haneda, president of the Japanese Medical Association, stated that "the establishment of the medical information network will be good for the development of continuing medical education for physicians. In this respect, the introduction of AMA data bases will contribute, on an experimental basis, to medical activities in Japan."

Mitsubishi Corp. is a diversified company, with interests in oil and refining, coal and metals mining, automobile and heavy machinery, foods, chemicals, textiles, and general merchandise. It is the largest *sogo sosha* or trading company in Japan. □

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# DRG monitoring continues

Over the past year the AMA has been conducting a DRG Monitoring Project. The purpose of the project, which is to continue for another two years, is to obtain a broad-based assessment of the early experiences of physicians with the prospective pricing system (PPS). During the first five months of the program, the AMA received responses from some 6,500 physicians. These responses formed the basis of the initial report of the project, which has been submitted to the Prospective Payment Assessment Commission and the Health Care Financing Administration. Copies of the report are available from the AMA's Department of Health Care Resources. Physicians are urged to continue to send descriptions of their experiences in a brief letter addressed to AMA's DRG Monitoring Project, Department of Health Care Resources, PO Box 10947, Chicago, IL 60610. □

## DEATHS

### James Floyd Moorman, MD 1900 - 1985

OSMA Life Member J. Floyd Moorman, MD, died in Oklahoma City on August 8. Dr Moorman, a 1925 graduate of the University of Louisville School of Medicine, was born in Leitchfield, Ky. He moved to Oklahoma City in 1925 to complete an internship at Saint Anthony Hospital and went on to establish a private practice in internal medicine with a special interest in pulmonary disease. He served as associate clinical professor of medicine at the University of Oklahoma School of Medicine from 1928 through 1968 and was a Fellow of the American College of Physicians.

### Oscar R. White, MD 1893 - 1985

Oklahoma City surgeon Oscar R. White, MD, a 1923 graduate of Northwestern University Medical School in Chicago, died on August 14. A captain and pilot in the US Air Force during World War I, Dr White established a private practice in Oklahoma City in 1926. He was a life member and Fellow of the American College of Surgeons, a professor emeritus at the University of Oklahoma School of Medicine, and a Life Member of the OSMA.

## IN MEMORIAM 1984

<i>Ingvald John Haugen, MD</i>	<i>September 1</i>
<i>Hugh H. Monroe, MD</i>	<i>September 9</i>
<i>Martin H. Bartlett, MD</i>	<i>September 10</i>
<i>Seth D. Revere, MD</i>	<i>October 6</i>
<i>Oliver H. Patterson, MD</i>	<i>October 13</i>
<i>Emmett H. Lindley, MD</i>	<i>November 8</i>
<i>Clark H. Hall, MD</i>	<i>December 5</i>
<i>Henry G. Bennett, Jr, MD</i>	<i>December 18</i>
<i>Adoniram V. Bowen, MD</i>	<i>December 29</i>

## 1985

<i>Owen L. Hill, MD</i>	<i>January 15</i>
<i>Earl M. Lusk, MD</i>	<i>January 30</i>
<i>Larry L. Lowery, MD</i>	<i>February 12</i>
<i>Harry Wilkins, MD</i>	<i>February 14</i>
<i>William H. Buchan, MD</i>	<i>February 15</i>
<i>Austin H. Bell, MD</i>	<i>February 23</i>
<i>Glen W. McDonald, MD</i>	<i>February 25</i>
<i>E.C. Lindley, MD</i>	<i>March 1</i>
<i>Charles W. Freeman, MD</i>	<i>March 5</i>
<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>Forest R. Brown, MD</i>	<i>March 19</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Hanna B. Karam, MD</i>	<i>March 28</i>
<i>Ernest S. Kerekes, MD</i>	<i>June 8</i>
<i>L. Chester McHenry, MD</i>	<i>June 8</i>
<i>Seigul J. Polk, MD</i>	<i>June 10</i>
<i>Murray M. Cash, MD</i>	<i>June 11</i>
<i>Franklin Jesse Nelson, MD</i>	<i>June 13</i>
<i>Robert L. Kendall, MD</i>	<i>June 21</i>
<i>Marion K. Ledbetter, MD</i>	<i>July 3</i>
<i>James Floyd Moorman, MD</i>	<i>August 8</i>
<i>Oscar R. White, MD</i>	<i>August 14</i>
<i>Maurice P. Capehart, MD</i>	<i>August 29</i>

### Maurice P. Capehart, MD 1918 - 1985

Spiro native Maurice P. Capehart, MD, retired neurosurgeon, died August 29 at his home in Tulsa. Dr Capehart earned his medical degree at the University of Oklahoma School of Medicine in 1944 and established a private practice in Tulsa in 1950. He retired from surgery in 1975 but continued working with the Tulsa Rehabilitation Center until his full retirement five years ago. Dr Capehart served in the US Navy during World War II.



### **Textbook of Pediatric Infectious Diseases.**

Two volumes. By Ralph D. Feigin and James D. Cherry. Philadelphia: W. B. Saunders Co., 1981. Pp 1,858, \$100.00.

Drs Feigin and Cherry have successfully provided an authoritative two-volume text dealing with infectious diseases, emphasizing their occurrence in childhood. It contains more than 1,800 pages, comprises forty-four chapters by 122 contributing authors, and discusses infection by organ system and by microorganism. It represents a complete and current compendium of information about pediatric infectious diseases.

The first volume consists of three general sections: discussion of the host-parasite relationship and the pathogenesis of infectious diseases, infections of specific organ systems, and infections with specific microorganisms. The second volume begins with specific infections caused by viruses and includes discussions of rickettsial, fungal, parasitic, mycoplasmal, and chlamydial diseases. Also included are sections on chemotherapy, infection control, aids to diagnosis of infection, and prevention of infections. In addition, there are certain chapters unique to the field of pediatric infectious diseases, such as those dealing with viral infections of the fetus and neonate and with immunology of the newborn. Each chapter dealing with a specific disease discusses in detail its history, etiology, epidemiology, pathophysiology, clinical aspects, differential diagnosis, treatment, prognosis, and prevention. A bibliography ends each chapter.

Inherent in a multiauthored textbook are certain drawbacks; however, here they are less numerous than usual. As might be expected, there is a variable quality in writing. In some chapters the description of historical aspects is somewhat excessive, which reduces the amount of space that can be given to other aspects of the disorder. There are several instances of duplication. For example, there is a discussion of group B beta hemolytic streptococcal infections in at least four different areas of the text (nosocomial infections, perinatal infections, respiratory tract infections, and group B streptococcal infections). The inescapable time lag between preparation of chapters and publication results in the omission of certain information such as discussion of newer antibiotics, eg the third-generation cephalosporins. Readers will have their own opinions about which diseases deserve more or less emphasis.

The major criticism I have is that the index is inconveniently located only in Volume Two. It would

be more easily used at the end of each volume.

The shortcomings of this textbook are far outweighed by its breadth, depth, and general excellence. The material is well organized, generally well done, comprehensive, and readable. I recommend it highly and expect it will become a standard reference.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Rickettsiae and Rickettsial Diseases.** Edited by Willy Burgdorfer and Robert L. Anacker. New York, etc.: Academic Press, 1981. Pp 650, price not given.

This volume contains the proceedings of the Conference on Rickettsiae and Rickettsial Diseases held at the Rocky Mountain Laboratories in Hamilton, Montana, in September 1980. Because in recent years there has been a steady increase in the number of cases of Rocky Mountain spotted fever, the conference was organized to assess the state of research on rickettsial diseases in the United States. It was attended by 104 scientists, 98 of whom were from the United States. The program and its proceedings include papers on immunity and immunology, ultrastructure, biology, biochemistry and metabolism, and the ecology and epidemiology of rickettsiae and/or rickettsial diseases. Dr Herald R. Cox, one of the pioneers in rickettsial disease research, is the author of an interesting chapter of reminiscences about Rocky Mountain spotted fever and the Rocky Mountain Laboratory. Dr Theodore E. Woodward of Baltimore provides a thoughtful review of certain unresolved problems in rickettsial diseases.

This book will not have a general appeal. However, it will be of interest to all workers dealing with rickettsial diseases.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**The Human Herpesviruses: An Interdisciplinary Perspective.** Edited by Andre J. Nahmais, Walter R. Dowdle, and Raymond F. Schinazi. New York: Elsevier/North Holland Inc., 1981. Pp 721, illustrated, \$89.00.

This volume on the herpesviruses in humans contains the presentations from the International Conference on Herpes Viruses held in Atlanta, Georgia, in March 1980. The material is organized into ten major sections; in addition there are five appendices. Embraced in the major categories is a wide variety

of topics including the epidemiology of infection and of disease, the wide clinical spectrum of disease caused by the herpesviruses, and appropriate diagnostic measures, including rapid viral diagnosis, treatment, and prevention. Part one, "Clinical Spectrum," includes the relevant clinical aspects of infections with herpes simplex viruses 1 and 2, of varicella-zoster, of cytomegalovirus, and of Epstein-Barr viruses. The molecular and genetic features as well as oncogenic properties and latency of these viruses are well described.

For each area of topics covered, the four human herpesviruses are given individual chapters. The chapters are informative and contain pertinent and up-to-date references. There is a good blend of work or contributions by basic virologists and by leaders in clinical virology. If there is a criticism of this work, it lies in the fact that some authors tend to speak only of their own work to the exclusion of that of others.

All-in-all this is an authoritative text about virtually all aspects of herpesviruses in humans. It is a useful reference.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**The Freezing of Mammalian Embryos.** Ciba Foundation Symposium 52 (new series). Amsterdam, Oxford, and New York: Elsevier/Excerpta Medica/North Holland, 1977. Pp 330, price not given.

This monograph contains the papers and discussions of the meeting held in London in January 1977. It concerns possible uses of frozen embryos in livestock production and in genetic research. There was also discussion of the possible applications in human medicine, which may give this particular symposium a larger than anticipated audience.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Laboratory Medicine: Hematology.** Fourth Edition. John B. Miale, MD. Saint Louis: The C.V. Mosby Company, 1978. Pp 1,318, illustrated, \$27.50.

This is the fourth edition of this very extensive treatise dealing with the various hematologic aspects of laboratory medicine. It is made up of fifteen chapters beginning with two on the reticuloendothelial system, followed by chapters entitled "Morphology of Blood and Bone Marrow Cells," "The Bone Marrow," "The Peripheral Blood," and three chapters discuss-

ing the erythrocyte and its disorders. The author discusses anemias in two categories: those due to decreased erythrocyte survival, into which group he places congenital and hemolytic anemias, and those due to decreased erythrocyte survival — the hemoglobinopathies. Following this is a section on leukocytes and diseases of leukopoiesis, a section on aplastic anemia and related disorders, and a final chapter on hemostasis and blood coagulation. This book contains 1,318 pages with 1,399 illustrations and 37 plates, including 10 in color. This volume is too extensive to be useful for the average physician but will serve as a useful reference for those whose primary concern is hematology.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Survivors, Victims, and Perpetrators: Essays on the Nazi Holocaust.** Edited by Joel E. Dimsdale. New York, etc: Hemisphere Publishing Corporation, 1980. Pp 474, \$19.50.

"No event in the memory of living humans is more significant than the Nazi Holocaust. It is significant not merely as a dramatic saga of profound tragedy, let alone a bizarre aberration of demented leadership, but also as a fundamental question of human survival in the future." This is how Dr David A. Hamburg, president of the Institute of Medicine, characterized the subject of this book. This volume is made up of a series of essays which provides an introduction to current and past research on the Nazi Holocaust.

The book is divided into three sections. Part One examines the historical setting of the Nazi concentration camps, considering in overview the behavior of the concentration camp inmates and the SS. This section analyzes the historical foundations of anti-Semitism and the rise of national socialism. Part Two focuses on the victims of the concentration camps. The survivors exhibit enormous physical and emotional problems resulting from their exposure to this massive stress, and there is indication that the children of these survivors experience similar difficulties. Part Three, the most controversial section, offers insights into the behavior of the perpetrators of the Holocaust. There is a rather surprising amount of data regarding the personality organization of the war criminals; many of them completed psychological testing at Nuremberg.

The contributors are all psychiatrists, psychologists, sociologists, or historians. The essays are



framed in a psychological structure, as would be expected.

Among the more interesting of the essays is that entitled "The SS Yesterday and Today: A Socio-psychological View," by John M. Steiner of the Department of Sociology, California State University. Steiner was an inmate of several concentration-death

camps and a participant in death marches.

The reader interested in this painful topic will find much new information here despite the repetition.

Harris D. Riley, Jr., MD  
Oklahoma City

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This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum  $K^+$  levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict  $K^+$  intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperurcemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

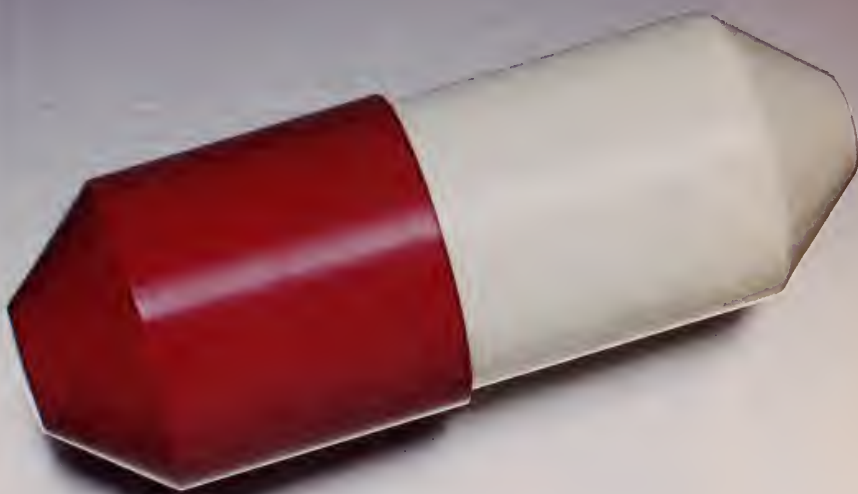
**Supplied:** 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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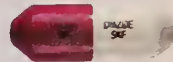
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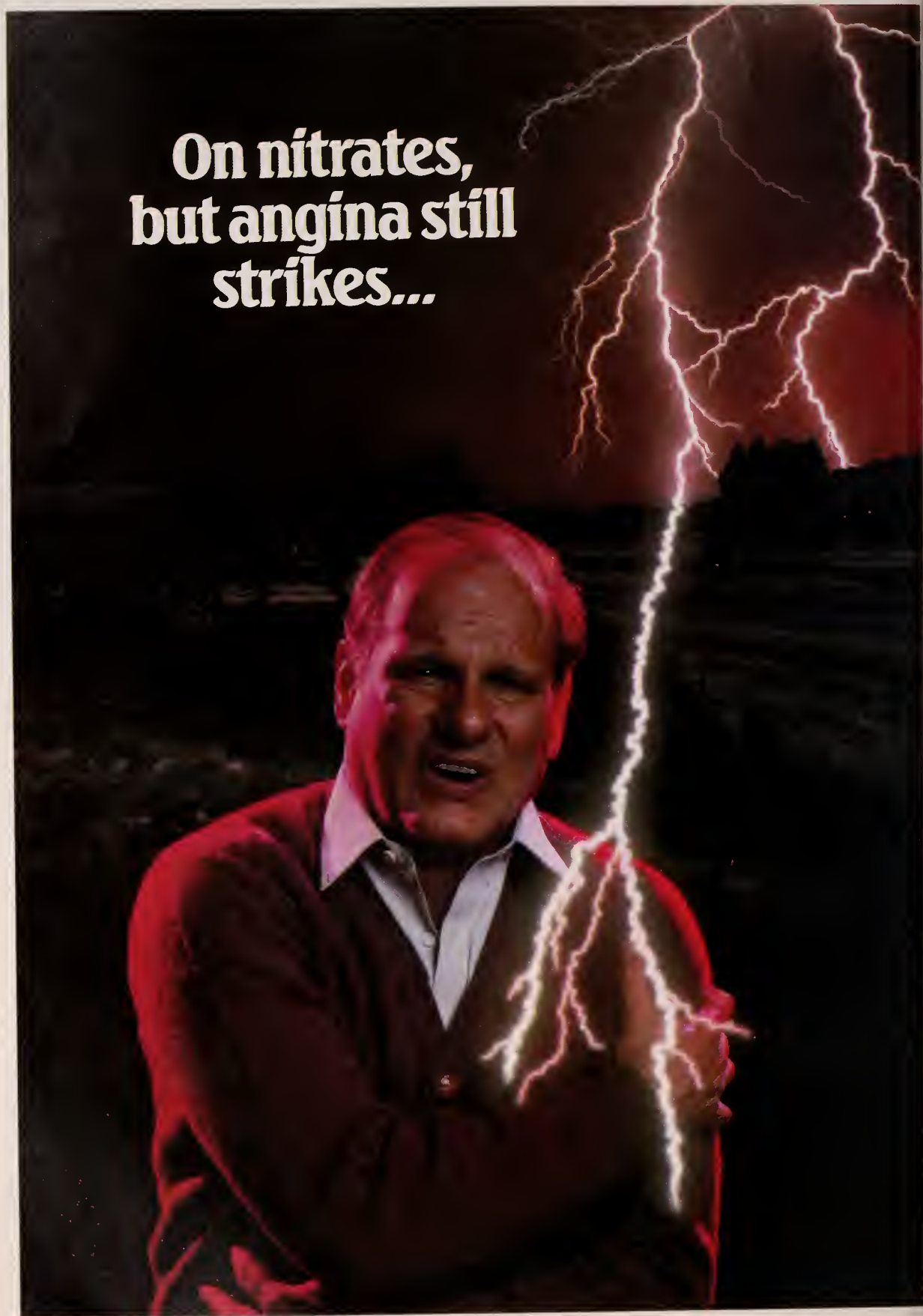
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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

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side effects.**



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80 mg and 120 mg scored, film-coated tablets

**Contraindications:** Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions*.) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions*.) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. **Pregnancy Category C:** There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385



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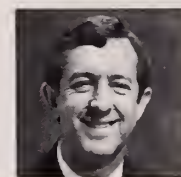
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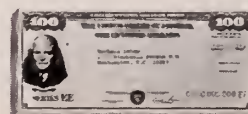
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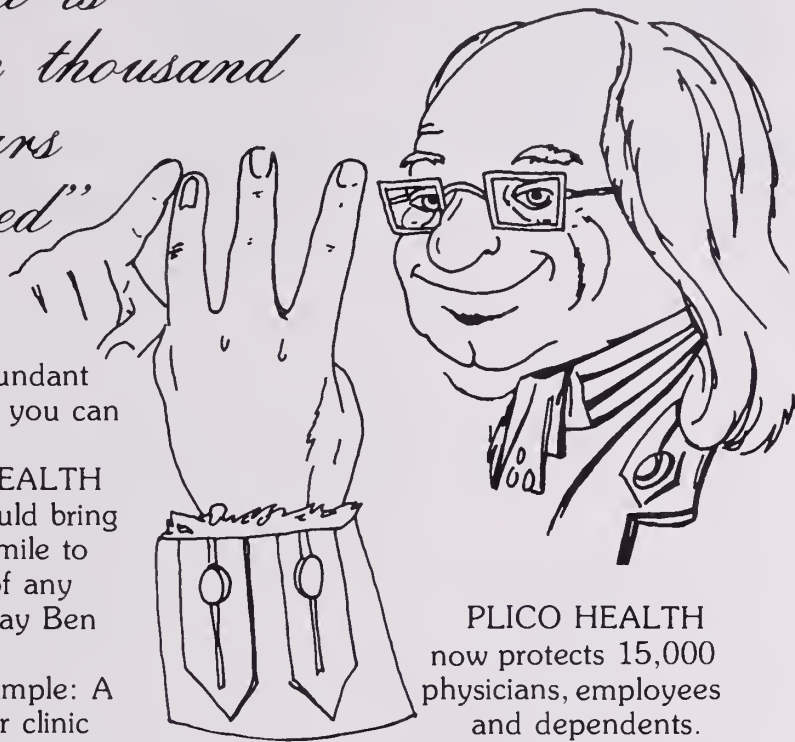
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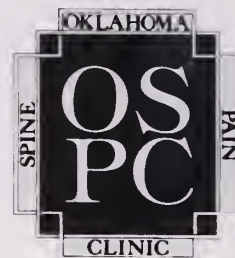
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## INDEX TO ADVERTISERS

The Arthritis Clinic .....	26A
The Cardiac Surgeons of Oklahoma City, Inc. ....	21A
Central Oklahoma Ambulatory Surgical Center, Inc. ....	28A
City of Faith .....	1A
Computers Plus Healthcare .....	396
Curtis 1000 Information Systems .....	4A
Dorsey Pharmaceuticals ( <i>Hydergine LC</i> ) .....	13A, 14A
Edmond Medical Plaza .....	402
For Doctors Only .....	28A
C. L. Frates & Co., Inc. ....	398
Frontier Federal Savings and Loan .....	5A
Glass-Nelson Clinic .....	24A
Harsha Orthopedic, Inc. ....	28A
Knoll Pharmaceutical Co. ( <i>Isoptin</i> ) .....	16A-18A
Eli Lilly Industries ( <i>Ceclor</i> ) .....	10A
McAlester Clinic .....	24A
Medical Arts Clinic of Ardmore .....	25A
Medical Arts Laboratory .....	27A
James B. Morris II & Associates .....	14A
Oklahoma Allergy Clinic .....	22A
Oklahoma Center for Athletes .....	22A
Oklahoma City Clinic .....	IFC
Oklahoma Hand Surgery Center, Inc. ....	27A
Oklahoma Lung Function Laboratory .....	27A
Oklahoma Urology Center .....	28A
OMPAC .....	12A
Orthopedic & Arthritis Center .....	25A
Orthopedic Associates .....	26A
OSMA Council on Member Services .....	11A
PLICO .....	19A
Prodata Medical Systems .....	8A
Quail Springs Corporate Plaza .....	2A
Rehabilitation Institute of Oklahoma .....	390
Roche Products, Inc. ( <i>Dalmane</i> ) .....	IBC, BC
Shawnee Medical Center Clinic, Inc. ....	23A
SmithKline Beckman ( <i>Dyazide</i> ) .....	15A
Southern Plains Medical Center, Inc. ....	23A
Tulsa Adjustment Bureau, Inc. ....	400
The Upjohn Company ( <i>Motrin 800</i> ) .....	9A
Willow View Hospital .....	20A
Windy Meadow Farm .....	6A, 7A

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## Medi-File

Medi-File, the project targeted at senior citizens, is currently being launched throughout the State of Oklahoma. The purpose of the Medi-File cards is to help in the prevention of drug misuse by acting as a memory aid. The Medi-File card is a credit card-sized folder on which senior citizens can list all current medications. The design of the card allows not only places for the drugs to be listed, but also places for listing when the drug was prescribed, the name of the prescribing physician, and the dosage. Standard features such as the patient's name, phone, and Medicare number can be recorded on the card. Additional features of the card include space for the listing of emergency contact persons and the patient's allergies.

These cards are made available free of charge to doctors who are members of the Oklahoma State Medical Association. Initial presentation of the project was made by the Oklahoma State Medical Association Auxiliary, based on a similar project undertaken jointly by the Florida Medical Association and the

Florida Medical Association Auxiliary. The Medi-File cards will be mailed from the Oklahoma State Medical Association office to physicians' offices. Additional cards may also be ordered through the OSMA office. Auxiliary members will help in the promoting and publicizing of the Medi-File cards.

Since many older persons have several doctors and are on several medications, Medi-File should be shown to each doctor at every visit. Medi-File will be of great help to the doctor in knowing all medications the patient is taking when he or she evaluates the patient's condition or if new medications need to be prescribed. Since Medi-File cards are conveniently kept in the wallet, they will be invaluable to the patient for their doctors' visits, emergencies, and hospital admissions.

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*Mrs Gary L. (Susan) Paddack  
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■ **The Tulsa County Medical Society is seeking** physicians who are fluent in one or more foreign languages. The TCMS receives inquiries from both the public and Tulsa area physicians regarding non-English-speaking patients. Bilingual practitioners in primary care are particularly needed. Physicians willing to assist are asked to call the TCMS at (918) 743-6184 or write 354 Utica Square Medical Center, Tulsa, OK 74114.

■ **The Office of Continuing Medical Education** at the University of Oklahoma College of Medicine has announced that the following courses will be offered in November: November 16 — Computers and Devices in Ophthalmology; November 21 and 22 — Emergency Medicine Update (Annual Meeting of the Oklahoma Chapter of the American College of Emergency Physicians); and November 21 to 23 — Chronically Ill and Aging. For additional information contact Magdalen De Bault, Associate Director, Continuing Medical Education, OU College of Medicine, PO Box 26901, Oklahoma City, OK 73190, or call (405) 271-2350.

■ **Survival was significantly prolonged in a** prospective study of pancreatic cancer patients treated with radiation and chemotherapy following surgery, researchers report in the August *Archives of Surgery*. Martin H. Kalser, MD, of the University of Miami, and Susan S. Ellenberg, PhD, of EMMES Corp., in Potomac, Md, say a study of 21 patients assigned to study and 22 to observational control had to be interrupted because combined therapy was so effective. "Median survival for the treatment group (20 months) was significantly longer than that observed for the control group (11 months)," the researchers say.

■ **A statewide organ donor hotline has been established** in Oklahoma City. The 24-hour hotline, 1-800-826-LIFE, will allow hospitals to alert Oklahoma organ and tissue retrieval systems of their needs and is also connected to national retrieval systems. Carol Cooper, program coordinator, believes Oklahoma is the only state with such a system.

■ **No current epidemiologic or microbiologic** evidence supports the theory that AIDS is transmitted by mosquitoes, writes D. Peter Drotman, MD, MPH, of the Centers for Disease Control in Atlanta, responding to a question in the *Journal of the American Medical Association*. "The bulk of evidence ar-

gues against routes of transmission other than sexual or blood related," he says. "In other countries, such as Haiti or countries in Central Africa, heterosexual transmission seems to play a more important role than in North America or Western Europe (where most AIDS patients are homosexual)." But insect-borne transmission has not been implicated in any country, and the relative absence of reported disease in preadolescent children argues against it, he concludes.

■ **The Retired Doctors Club in Oklahoma City** is now three years old and has over 50 members on its roster. The club meets once a month and levies no dues or membership fees. Its current officers are Hervey A. Foerster, MD, president; Sanford Mathews, MD, vice-president; and Phillip Tullis, MD, secretary. Persons interested in joining the organization should contact Dr Foerster, 1503 Camden Way, Oklahoma City, OK 73116.

■ **Oklahoma physicians are reminded that their** Thirteenth Annual Winter Seminar will be at Copper Mountain, Colo, this year. While group rates on accommodations are no longer available, reservations may still be made to attend the conference, which runs from December 27 through January 3. Plan a winter vacation now and participate in a seminar certified for AMA and other credit hours. For information call (405) 949-0548.

■ **The American College of Physicians (ACP)** has scheduled one of its regional scientific CME meetings for November 7-10 at Shangri-La Lodge, Afton, Oklahoma. For further information contact William L. Hughes, MD, FACP, Memorial Professional Building, Suite 200, 13439 North Broadway Extension, Oklahoma City, OK 73114, (405) 751-4344.

■ **Results of a double-blind placebo-controlled** trial of polysorbate 60, a nonionic detergent, indicate that the substance is ineffective, despite anecdotal reports of its ability to cure male pattern baldness. Howard D. Groveman, MD, and colleagues from the University of California, San Diego, say 141 subjects completed a 16-week trial and that no measurable differences in new hair growth were noted. However, some participants perceived new hair growth, which did not correlate with measurements. "The placebo effect may be a major factor in reports of baldness 'cures,'" the researchers comment in the August *Archives of Internal Medicine*.

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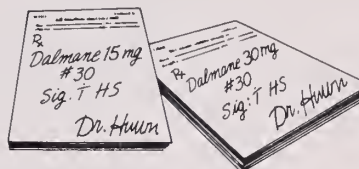
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**Precautions:** In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, e.g. excitement, stimulation and hyperactivity.

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# JOURNAL

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VOL. 78, No. 11

#### EDITORIAL

Some Ironies About Housecleaning ..... 407  
MARK R. JOHNSON, MD

President's Page ..... 408  
ELVIN M. AMEN, MD

#### SCIENTIFIC

Home Care: A Better Alternative for the Ventilator-  
Dependent Child ..... 409  
SANTIAGO REYES DE LA ROCHA, MD

Hypertension II: Statistical Correlation of Seventy-  
eight Diet Components to Blood Pressure ..... 414  
ASEGASH TSEGAYE, PHD; CHARLES R. RITCHEY, MS;  
ROBERT D. MORRISON, PHD

#### SPECIAL

An Analysis of Petitions for Court Commitment to  
Psychiatric Care Filed in Tulsa County ..... 420  
JOHN F. GAJDA, MA

#### NEWS ..... 429

AMA issues guidelines for AIDS patients . . . Five Life Mem-  
berships approved in August . . . TCMS issues \$33,000 in  
scholarships . . . OSMA Auxiliary holds annual confluence  
. . . AMA reports trends in medical school enrollments . . .  
DRGs driving ERs to "dumping"? . . . Hypothermia less com-  
mon in elderly than suspected

#### DEPARTMENTS

State Department	Index to
of Health ..... 426	Advertisers ..... 34A
Deaths ..... 436	Instructions
In Memoriam ..... 436	for Authors ..... 34A
Reaction Time ..... 437	Auxiliary ..... 35A
Book Reviews ..... 438	The Last Word ..... 36A
Miscellaneous Adv. ... 13A	

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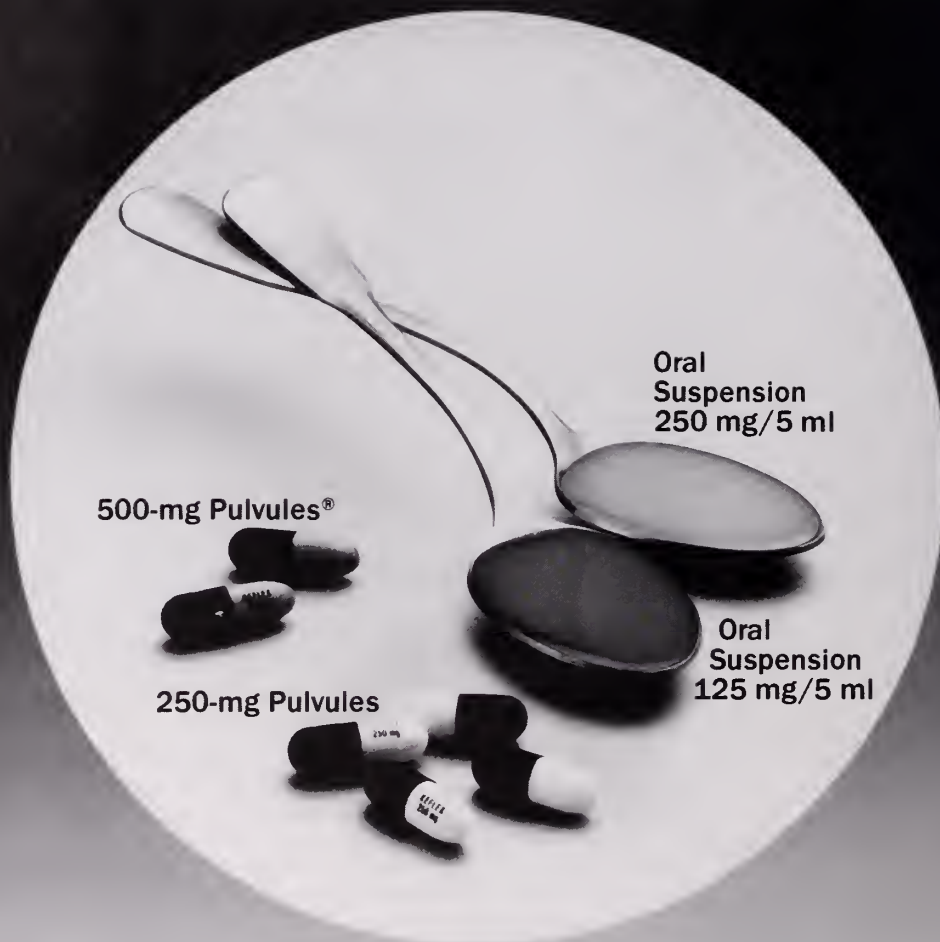
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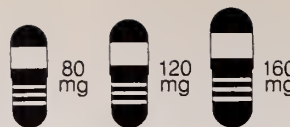
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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal, as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are: (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

**INDICATIONS AND USAGE.** **Hypertension:** Inderal LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** Inderal LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** Inderal is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

**WARNINGS.** **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.** Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**MAJOR SURGERY.** The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g. dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

**DIABETES AND HYPOGLYCEMIA.** Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

**THYROTOXICOSIS.** Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** **General.** Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

**Clinical Laboratory Tests.** Elevated blood urea levels in patients with severe heart disease elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**DRUG INTERACTIONS.** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

**Pregnancy.** Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

**Cardiovascular.** bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

**Central Nervous System.** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

**Gastrointestinal.** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic.** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory.** bronchospasm.

**Hematologic.** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Auto-Immune.** In extremely rare instances, systemic lupus erythematosus has been reported.

**Miscellaneous.** alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

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**PEDIATRIC DOSAGE—**At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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## Some Ironies About Housecleaning

Very often I hear pointed comments about the need for the medical profession to "police itself" or "clean its own house." Currently such action is being promoted as a remedy for the malpractice crisis, usually by spokesmen for those who deny that such a crisis exists, while strongly implying that we physicians are finally getting what we deserve.

Although a bit more devious than the customary slander, this is another example of burying the truth in order to defame and discredit physicians and their profession. We are portrayed as an exclusive club of smug, self-serving autocrats who not only refuse to expel incompetent members but actually deny that we are subject to the frailties of the human organism. Unfortunately, the market for such nonsense is large and still unsaturated.

Viewed in the light of factual truths, bitter ironies emerge from the fabricated accusations that the medical profession makes no effort to identify and discipline its miscreants.

First among the ironies is that the most competent physicians in a community are among the most apt to be the targets of malpractice suits. The reasons are conjectural but rational: Such physicians are highly visible; they are referred the most complex, challenging, and desperate cases; they are sought as last-hope consultants by many patients, families, and primary care colleagues; they have the skill and courage and dedication to venture where angels fear to trend.

Another irony, companion to the first, is that the truly incompetent physicians, like the unlicensed charlatans and the medical fringe cultists, are the least likely to be named in malpractice suits. Again, conjecture: They do nothing and therefore do little harm — except through embezzlement and fraud; they take no risks; they are con artists whose only

skill is in cultivating unshakable confidence; they admit no mistakes; they keep no honest records, and they are relatively judgment proof.

Bitterest of all the ironies is the fact that when our truly competent colleagues *do* initiate conscientious efforts to discipline, censure, or expel our incompetent colleagues, they not only fail to accomplish their courageous task, but they are themselves visited by disaster. They are often humiliated, sued, indicted, tried, convicted, and heavily fined for a variety of dastardly deeds. In the course of due process the heroic efforts of a competent accuser frequently will incite the ire of a number of federal and state agencies, a dozen voluntary protectors of human rights, a hundred defenders of freedom, an entire hierarchy of judges, and — of course — one or more lawyers who, motivated by pure altruism, will prove to a jury that the accused is the innocent victim of the accuser and must be exonerated, reinstated, and compensated for the outrageous injuries he has suffered.

The legal issues in such cases almost never address the questions of the competency, honesty, or integrity of the accused. Such issues are wholly ignored and the accuser is charged with and frequently found guilty of violating some law enforced by some federal or state regulatory agency.

As a final irony, consider this: The lawyer who succeeds in preserving for an incompetent, derelict physician the right to practice medicine can and probably will be called upon to defend the same client in a number of legitimate and thoroughly justifiable malpractice actions.

It's all perfectly possible. It's all perfectly ethical. It's all perfectly clear. We physicians just need to clean our own house.

—MRJ



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Do you keep records that give an accurate picture of the patient's condition and progress? Try harder. Don't give a plaintiff's lawyer unnecessary help.

Have you carelessly spoken thoughtless words about a colleague? Have you criticized a physician's care or results without thinking? Try harder to avoid creating distrust.

Have you helped your church with its worship or business affairs? Try harder.

Are you involved in civic activities of your community? Try harder.

Let's all work toward a better world for doctors and patients.

Get Involved — Participate!

Sincerely,

Elvin M. Amen, M.D.

# Home Care: A Better Alternative for the Ventilator-Dependent Child

SANTIAGO REYES de la ROCHA, MD

**Ventilator-dependent children may become expensive residents of health care institutions. Home care offers them better development, greater happiness, and more normal lives. It also has distinct economic advantages.**

**A**dvances in medical and other technology and improved coordination in health services have produced a group of children who have survived life-threatening disease or injury but who are now dependent on mechanical ventilation. These include children with various types of pulmonary disease, neuromuscular disease, and spinal cord injury. Because of their chronic respiratory failure, the need for mechanical breathing equipment, and the many health needs of these children, it is often customary to consider them as more-or-less permanent hospital patients. Yet it is abundantly clear that, despite modifications, a hospital is not the optimum environment for the growth and development of a child. In addition, the cost of hospital care for a ventilator-dependent child is enormous, particularly now, when health institutions are being increasingly stressed.<sup>1</sup> The experience with poliomyelitis patients with chronic, severe respiratory failure in the period before the development and use of poliovirus vaccine conclusively demonstrated that patients dependent on

mechanical ventilation could be successfully managed at home.<sup>2</sup>

This article will discuss home care for the ventilator-dependent child as perhaps the best alternative for long-term management when the development of the child and cost effectiveness are considered. Sending a patient home on a ventilator calls for a multidisciplinary team approach for the evaluation, management, discharge planning, and follow-up of the child. The functions of the team members, as well as the process of preparing the child and family to return to the community, are described.

## Ventilator-Dependent Population

The population of technology-dependent patients at Oklahoma Children's Memorial Hospital (OCMH) has grown in recent years. There are six ventilator-dependent children in our facility; four of them are accident victims with high spinal cord injuries. The other two are afflicted with neuromuscular disorders. As in most institutions, these patients stayed in the Intensive Care Unit (ICU) only during the initial acute stage of stabilization. To date we don't have a unit exclusively for the care of these patients. We have sent home two ventilator-dependent children; they have rejoined their communities, attending a regular school and church and participating in activities such as the Special Olympics. In a four-year period we can report only one complication related to home ventilation, a pneumothorax caused by an accidental alteration in the volume of the respirator.

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Table 1. Expenses for One-Year Period of Three Ventilator-Dependent Children at Oklahoma Children's Memorial Hospital Compared to the Expenses During the Same Time of a Patient in Home Ventilation

Patient	Nature of Illness	Hospital Charges	Physician's Fees	Total
1	Spinal cord injury	\$231,801.98	\$10,980.00	\$242,781.98
2	Spinal cord injury	\$236,984.64	\$ 7,320.00	\$244,304.64
3	Neuro-muscular disorder	\$292,010.06	\$ 9,150.00	\$301,160.06
Patient	Nature of Illness	Home Ventilation Costs	Physician's Fees	Total
4	Neuro-muscular disorder	\$ 1,236.00	\$ 60.00	\$ 1,296.00

In some major medical centers, ventilator-dependent patients have been grouped in specialized units in which a homelike environment is the ultimate goal. This includes attendance in school, participation in recreational activities, and the use of the simplest possible life-support and monitoring equipment. Although this represents a considerable improvement in the child's care, development, and emotional well-being, the best option for the ventilator-dependent child is the most stable and warm environment possible. In most instances, this is at home with his or her own family.

## The Importance of Home Care

**Psychosocial and emotional factors.** Prolonged hospitalization in intensive care units and long-term institutionalization of children has been associated with acute disruption and significant alterations of their potentials for development.<sup>3</sup> Chronically ill children eventually will adapt to their disease and need to be treated like other children. When a child faces chronic hospitalization, the home dynamics are grossly altered, and every member of the family is affected. The return of the hospitalized child to the home promotes a better interaction and restores the family unit.<sup>4</sup>

The medical literature confirms a remarkable improvement in psychosocial development as well as in spiritual and academic growth, once ventilator-dependent children return to their homes.<sup>5</sup> It is estimated that, nationwide, more than 175 ventilator-dependent children have been discharged from institutions during the last few years.<sup>6</sup> This interest in the community-based ventilator-dependent patient does not represent a new concept in management. As mentioned previously, many poliomyelitis patients have been successfully managed at home in negative-pressure ventilators (iron lungs); many of them are still active members of the community.<sup>7</sup> Unfortunately, except for a few centers, the possibilities and potentials of home ventilation have been overlooked.

Data from Children's Memorial Hospital in Chicago revealed that the cost of intensive and inter-

mediate care is reaching alarming proportions. In a few years, the per diem rate of care increased an overall of 84% in some centers. On the other hand, the same study reported a decrease of 30% in health care costs when an intermediate-care facility became operational and a further reduction of 70% when the patients were placed in the community.<sup>3</sup>

The expenses for mechanical ventilation at home are variable, depending on many factors. The greatest expense is nursing assistance. The cost of 24-hours of skilled nursing care varies across the country from \$5,040.00<sup>8</sup> to \$15,000.00 per month.<sup>7</sup> Although these costs may appear to be exorbitantly high, they represent a significant saving when compared to the expense of caring for a ventilator-dependent patient in the hospital. Generally, the costs for health care may be reduced by 50% or more when the ventilator-dependent patient is cared for at home.<sup>6,7</sup>

Table 1 shows the health care costs of three ventilator-dependent children for a one-year period at Oklahoma Children's Memorial Hospital compared with those of a ventilator-dependent patient managed at home during the same time. As Table 1 indicates, the cost of health care for the hospitalized patients was significantly higher than for the patient living at home. Patient number 4, during the chronic stage of his hospitalization, averaged expenses of \$22,511.20 per month. Although the case of this patient is exceptional because he comes from a large family that provides his total care without the help of professional nursing agencies, the point for comparison is valid. The recent medical literature on the subject of ventilator-dependent patients indicates that home care not only is cost effective, but offers the patient an opportunity for a better quality of life. Yet the cost of identifying resources remains the predominant limitation in the development of home-ventilator programs.

## The Care of the Ventilator-Dependent Child

**The family and home environment.** Without the willingness of the family to receive the child on a ventilator, the attempt is condemned to failure. Pro-

viding some help for the family is of vital importance. It is undesirable to place the total responsibility for the patient's care on the parents. They are entitled to a normal life, and nursing assistance in varying degrees provides help and security, and allows parents time to take care of other members of the family as well as their own affairs.

The home where the child is to live should, ideally, be in a community able to provide for the patient's education and for emergency services. It should have sufficient space for the mobility of the patient with the wheelchair, living space, and storage. The home's wiring should be adequate for the load of extra electrical equipment. Structural modifications such as the widening of doorways and the construction of ramps are some of the home modifications necessary for the ventilator-dependent child.

A hospital undertaking the care of ventilator-dependent children must establish an organized program that addresses both hospital and home care. It is the purpose of this paper to discuss the home care of such patients, and hospital care is alluded to only to provide transition.

**The health care team.** This group is essential and must function during both the hospital and home care of the patient. The management of a child dependent on a ventilator is an enormously complex process. It requires the services and collaboration of a multidisciplinary health team for all aspects of care. Each member of the team has important and specific roles which many times start as soon as the patient is hospitalized; the responsibility does not end with the child's discharge but continues in the form of supervision of the home program and follow-up. The functions of only a few team members will be specifically discussed here.

**Medical director and codirector.** These physicians provide leadership and overall direction to the team. The physicians have the ultimate responsibility for decision-making and for the care and safety of the patient. Physicians involved in this type of program should be pediatricians experienced in pulmonary care and ventilator management.

**Administrator-coordinator.** This person could be a professional in the health field, such as a physician assistant, registered nurse, medical social worker, or respiratory therapist. His/her function, as the name implies, is of paramount importance: he is responsible for coordinating the different types of management during hospitalization, arranging for the equipment to be purchased for home use, directing the educational program, planning the patient's discharge, and coordinating vendors and other caretakers for proper management and follow-up when the child goes home.

**Social worker.** The social worker plays a valuable role in a home ventilator program. He/she will assess the home situation, family dynamics, and available resources, making necessary referrals for possible economic assistance. The social worker usually establishes a very close relationship with the family. He helps them to understand the implications of the child's condition as well as of home ventilation and acts as a counselor and family advocate. Along with the administrator-coordinator, he helps in the identification of caretakers within the extended family or locates care provider agencies to assure proper back-up nursing and respiratory care in the home. Finally, among other functions, he makes arrangements for and referrals to the county social services and other emergency services in the community.

**Other members.** Other no less important team members include the respiratory therapist, psychologist, physical therapist, school teacher, rehabilitation engineer, biomedical engineer, nutritionist, and occupational therapist, with the help of other consultants from different pediatric subspecialties.

**In-hospital component.** Once the patient is referred to the program, the case is screened by the physician, administrator-coordinator, social worker, and psychologist. This screening is not restricted to an evaluation of the individual patient, but includes an assessment of the immediate and extended family, resources, and home environment.

During hospitalization, the child undergoes a thorough evaluation. Total management aims toward

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**The costs  
may reduced  
by 50% or more  
when the patient  
is cared for at home.**

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medical stabilization, improvement of the patient's psychoemotional status, and maximum adaptation to the activities of daily living. During this time, ventilator adjustments are made to achieve optimal ventilation. A complete psychological evaluation with appropriate follow-up during hospitalization is mandatory, as is an educational assessment, so that insofar as possible the child can resume school work at the earliest possible time.

Ideally, the nursing unit in which the patient is hospitalized should offer a homelike environment. Nursing personnel and others in contact with the



patient should be informed of this goal and should try to avoid an "ICU-like" atmosphere despite the use of respiratory equipment. The regular hospital routine may be adapted to the patient's situation to promote a better environment with a minimal amount of stress.

**Education.** The educational process involves the patient, the immediate family, the extended family, and sometimes other home caretakers. They must learn about the patient's condition, prognosis, and total home management, including cardiopulmonary resuscitation, nursing, and respiratory care, and also maintenance and simple repairs of the equipment.

Before the patient is discharged from the hospital, the family should demonstrate, to the satisfaction of the team members involved, competence in all aspects of home care. This competence constitutes one of the most important criteria for discharge.

**Resources.** Ideally, financial resources in the community should reimburse 100% of the necessary equipment and home care expenses. The uncertainty of the availability of funds is a great detriment to the success of the program. Fortunately, insurance companies are becoming increasingly aware of the significant savings involved in the home care of ventilator-dependent patients; some of them are already reimbursing the total cost. Private foundations, local charitable groups, and national organizations such as SKIP (Sick Kids Need Involved People) are important sources of funds. In many states, agencies are recognizing the advantages of home ventilation and are providing funds for the creation and management of such programs. It is felt that in the near future, state and nationwide programs will be developed in the realization that, for many reasons, sending the child home on a ventilator constitutes perhaps the most acceptable solution. Written confirmation from third parties guaranteeing funding for medical equipment, disposables, and home caretakers should be obtained whenever possible.

Difficulties in securing funds for equipment and in identifying home vendors accounts for most of the delay encountered in home discharges.

## How to Arrange and Provide Care at Home

**Discharge planning.** This is an extremely important phase of the program. Only in exceptional cases can the family provide total nursing care. If possible, 24-hour nursing care should be arranged for the patient's first few weeks at home; the amount of assistance can be decreased as the family's confidence increases. A well developed, detailed, written discharge plan should be presented and discussed with the family. Every aspect of the child's care, as well as plans for emergency situations, should be outlined;

**Table 2.—Essential Equipment for Home Positive-Pressure Ventilation**

1. Ventilator with circuits and parts (portable, positive pressure), back-up unit
2. Humidifier for ventilator
3. Manual resuscitator
4. Suction machine with tubing
5. Electric wheelchair with batteries
6. Battery charger with cables
7. Oxygen cylinder (H) with regulator, portable cylinder (D)
8. Alarm
9. Tracheostomy cannulas
10. Hospital bed, stethoscope, nebulizers (optional)
11. Miscellaneous/disposables: catheters, gloves, syringes, nebulizers, alcohol, povidone-iodine soap, dressings

this report may serve as an educational tool as well as a reference for the patient and his caretakers.<sup>9</sup>

Another very important part of home care is the selection of vendors to provide supplies and equipment and of caretakers' agencies. They should be selected according to their ability to supply services on a 24-hour basis, as well as their reliability and competitive rates.<sup>9</sup> Vendors and caretakers should meet the child and the family before hospital discharge; the persons selected by the agencies should get to know the child while he or she is still in the hospital. In this way, the patient will be more comfortable with the care they provide at home. If possible, the equipment should be the same type used in the hospital (Table 2); it should be installed in the home prior to the patient's arrival in order to avoid unnecessary stress and ease the transition.

Referral to local physicians, county social workers, and others, as well as notification to community services such as the police, paramedics, fire fighters, and electric company, should be arranged prior to the patient's discharge. Informing these agencies that a patient on a breathing aid will be returning to their area is mandatory. Follow-up should be the duty of the team members. Vendors and home caretakers should report periodically to the administrator-coordinator about the patient's condition and related issues. Telephone contact is advised between follow-up visits.

One of the goals of the home care program is to maintain as normal a life as possible for the ventilator-dependent child. This includes the opportunity to receive an education; in Oklahoma, these children are entitled to this by law. During the first few weeks or months at home, a visiting teacher can be provided by the school system. Because of limited patient tolerance, the teacher may at first work on a part-time basis, with a view to eventually increasing the time to a full schedule. Once the child is

willing and ready to attend school, an attendant, usually arranged and trained by the school system, can provide assistance with school work. Some patients may not be strong enough for a full school day; an acceptable alternative in these cases is half a day, with the remainder of the schedule provided by the visiting teacher at the child's home.

Despite the significant advantages of home care, such as the child's overall progress, the intact family unit, and the decreased expenses, there could also be significant disadvantages, including the responsibilities placed on the family, outsiders interfering with the family life, and being away from the hospital in the case of a major medical emergency.<sup>4</sup>

Summary

Although our experience with in-home ventilators at Oklahoma Children's Memorial Hospital involves only two patients, we care for six ventilator-dependent children. The trend of continuous improvement in medical care will produce a large number of technology-dependent patients, and the establishment of a state-supported home ventilator program is becoming a matter of imminent necessity. Such a program could operate a statewide ventilator network to coordinate and centralize the care of ventilator-dependent patients at home. The program could be based on a transitional ventilator unit for the management and training of ventilator-dependent patients and their immediate caretakers. This unit could also be used for developing educational and research projects related to this fascinating field. Furthermore, medical and other health-related personnel interested in establishing similar programs could receive their training and develop their skills in this unit. Results to date favor this type of management; certainly, the success of this type of enterprise depends on the meticulous selection of patients, the

enthusiasm and dedication of the multidisciplinary team, and the availability of economical resources.

In this review we have summarized in a simplistic manner the issue of home care for ventilator-dependent children. We have tried to offer a wide view of the subject, emphasizing the benefits derived by the patients and the cost effectiveness of this form of therapy in an effort to inform the medical community and to promote the creation of such a program in the State of Oklahoma. □

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Coming in December . . .

Currently being considered for publication in the December issue are a manuscript on airborne bacterial contamination from mechanical ventilators, a comparison of two tests that determine the presence of antibody to rubella, and case reports on legionnaires' disease and botulism.



## *Hypertension II*

# Statistical Correlation of Seventy-eight Diet Components to Blood Pressure

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Out of 78 dietary components that were statistically evaluated, 73 correlated with the measured blood parameters and 5 were not significant. Dietary cholesterol has no statistical correlation with serum cholesterol in either black or white individuals, but it has a relationship with the blood pressure in men. Diet has no correlation with high-density lipoprotein cholesterol. Dietary sodium has a significant correlation with blood pressure in the white man, while copper has a significant correlation with blood pressure in the black man.

Even though habitual salt intake has no relation to physiological need, the average salt consumption in this country is at least ten times the body's need. Many of the processed foods that make up the typical American's diet contain relatively large amounts of salt<sup>2,3</sup> and low amount of fiber.<sup>3</sup> Furthermore, most western diets contain low amounts of polyunsaturated fats and large amounts of animal fats, which have been associated with high blood pressure and atherosclerosis.<sup>4</sup>

Epidemiological studies have shown that the incidence of coronary heart disease (CHD) is related to fat intake.<sup>5</sup> High levels of saturated dietary fats result in high serum cholesterol.<sup>6</sup> Yano et al<sup>7</sup> suggested that consumption of more carbohydrates lowers the

risk of CHD. There is a substantial reduction in the number of deaths from CHD in men when dairy fats in their diets are replaced by vegetable oils,<sup>8</sup> and it was shown that the level of serum cholesterol was lowered by the dietary substitution. Even though CHD cannot be eradicated by diet alone, Turpeinen<sup>8</sup> proposed that the problem can be alleviated by lowering saturated fat and cholesterol content in the diet and by increasing polyunsaturated fats.<sup>8,9</sup> On the other hand, Kritchevsky<sup>10</sup> stated that the plasma cholesterol level is related not only to the lipid component of the diet but to all dietary aspects.

Wright et al<sup>11</sup> showed that people on high fiber diets have lower mean blood pressures than those on low fiber diets. Even though it is not statistically significant, substituting polyunsaturated fats for the saturated fats in both low and high fiber diets resulted in a reduced blood pressure. In addition, Dodson<sup>12</sup> found that low fat, low sodium, high potassium, and high fiber diets are important in the prevention or treatment of hypertension. People on this diet do not show an increased blood pressure with age. Many investigations have shown that there is a relationship between elevated dietary sodium intake and high blood pressure.<sup>1,13-15</sup>

Mertz<sup>16</sup> stated that copper deficiency causes the elevation of cholesterol, while increased zinc consumption caused no change in total cholesterol level but did cause a decrease in the level of high-density lipoprotein (HDL) cholesterol. Increased consumption of chromium resulted in an increase in HDL cholesterol and a decrease in total cholesterol. In ad-

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Table 1a.—Correlation of Some Diet Components and Blood Parameters Adjusted to Age 50

Dietary Component	Blood parameters								Systolic Pressure	Diastolic Pressure
	Cholesterol	HDL Cholesterol	Cholesterol/HDL Cholesterol	LDL Cholesterol/HDL Cholesterol	Triglycerides	BUN	Sodium	Potassium		
Calories	WF*		WM-		WF*		WM*	WM**		
Animal protein					WM-				WM**	
Total Protein			BF*		WM-	BM*	BM-	WM*	WM**	BF*
Animal fat	WF*						BF*		WM**	
Cholesterol									WM*	BM-
Hydrogenated fat							BF-			
Monounsaturated fatty acids			WM*		WM-		WM*	WM**		
Polyunsaturated fatty acids			WM-		WM-			WM**		
Saturated fatty acids	WF*		WM*		WM-		WM*	WM*		
Total fat			WM-		WM-		WM*	WM**		
Vegetable fat			WM-		WM-			WM*	WM-	

BF = Black female, BM = Black male, WF = White female, WM = White male, \* = Significant at the 0.05 probability level, \*\* = Significant at the 0.01 probability level, - = Negative correlation.

dition, iodine deficiency causes an increase in the level of serum lipids.

Manthey et al<sup>17</sup> reported that a deficiency of magnesium may be present in patients with CHD, but elevated serum copper and manganese levels do not influence the development of CHD. Yet Borhani<sup>18</sup> reported that people who died of CHD had low levels of zinc and high levels of copper and that excessive consumption of cobalt resulted in myocardial damage. A positive correlation between zinc and atherosclerotic disease at the 0.05 probability level has been shown by Valentine and Chambers.<sup>19</sup>

It was shown that hypertensive patients excrete 40 to 50 times as much cadmium in their urine as do normotensive people.<sup>20</sup> Increased intake of dietary protein does not affect the plasma mineral levels — namely those of calcium, copper, iron, magnesium, phosphorus, and zinc.<sup>21</sup>

Since high levels of sodium, cholesterol, saturated fats, and animal protein in the diet are linked to hypertension and CHD, we chose to study these variables to determine their effect on blood pressure and other blood parameters. If the effects of diet upon blood pressure can be determined, it may be possible to reduce the incidence of hypertension through prevention, which is the best way of treating this disease.

## Materials and Methods

One hundred thirty-six volunteers from five communities in Oklahoma were asked to list their total food intake, including all beverages and snacks, for a period of eight days. The first recorded day corresponded with the first sampling of blood, and the last recorded day with the second sampling of blood.

The dietary data were encoded by using the nutritional analysis system supplied by the Department of Experimental Statistics, Louisiana State University, Baton Rouge; this system of analysis is based upon a computer compilation of the composition of foods listed in *Handbook 8*<sup>22</sup> and current published literature. Following the encoding, the data were transferred to a magnetic tape and sent to Louisiana State University. The dietary listing was analyzed for 78 components. From these 78 components, 73 were chosen because of their significance. These 73 components were correlated with the 10 blood parameters measured previously.<sup>23</sup>

All the dietary data were adjusted to age 50 years for each race and sex since there was a linear relationship between the response variables and age. The adjusted values were then analyzed in a two-way classification factorial experiment in which one of the factors was race and the other was sex. This is a two-by-two factorial in which the pooled variation among subjects within the races and sexes was used as an experimental error. The race-sex group means were used to compare the difference between the races, the difference between the sexes, and the interaction of races and sexes.

## Results and Discussion

Tables 1 a-c show the significant correlations of dietary components with the measured blood parameters, and Table 2 summarizes the data. All correlations presented in the results and discussion refer to these tables.

One of the major concerns of many Americans is cholesterol as it relates to cardiovascular disease.



Table 1b.—Correlation of Some Diet Components and Blood Parameters Adjusted to Age 50

Dietary Component	Blood parameters									
	Cholesterol	HDL Cholesterol	Cholesterol/HDL Cholesterol	LDL Cholesterol/HDL Cholesterol	Triglycerides	BUN	Sodium	Potassium	Systolic Pressure	Diastolic Pressure
Calcium					WF*				WM**	
Chromium			BF** WM**	BF*	WM**			WM-		
Cobalt								WM*	BM-	
Copper						WM*		WF-	BM**	BM**
Fluorine						WM*		WF**	BM-	
Iron					WF- WM-*					BF*
Magnesium					WF**					
Manganese						BF*				
Molybdenum	BF* WF*				WF**			WM*		
Phosphorus					WF*				BM- WM**	
Potassium					WM-				BM-	
Selenium						WF*			BM-	
Sodium									WM*	
Zinc					WM-		WM**			

BF = Black female, BM = Black male, WF = White female, WM = White male, \* = Significant at the 0.05 probability level, \*\* = Significant at the 0.01 probability level, - = Negative correlation.

This study showed that, as both black and white women age, their dietary cholesterol levels increase significantly; however, the level of significance is greater in the white than in the black woman. In both blacks and whites, dietary cholesterol has no correlation with serum cholesterol, but it does have a significant positive correlation with systolic blood pressure in white men and a negative correlation with diastolic blood pressure in black men. Rieser<sup>24</sup> stated that the average person's serum cholesterol level remains within the same normal values regardless of the diet. Our result is in general agreement with Rieser's, except for dietary saturated fats, which have a significant correlation with the serum cholesterol level in the white woman (Table 1a) and with molybdenum in both black and white women (Table 1b).

Regression analysis showed that as a black woman ages, the intake of hydrogenated fats and unsaturated fats increases slightly, but apparently this increase is not great enough to bring about the change in serum cholesterol that Turpeinen<sup>8</sup> observed. In both black and white men, the intake of dietary total fats (animal and vegetable) decreases with increasing age. Sinclair<sup>25</sup> reported that mono-unsaturated fatty acids have no effect on plasma cholesterol; our study is in agreement with his report (Table 1a). Total fat has a significant negative correlation with triglycerides and cholesterol/HDL cholesterol,

and a positive correlation with sodium and potassium only in the white man. Animal fat has a significant positive correlation with sodium in the black woman, a positive correlation with cholesterol in the white woman, and a positive correlation with systolic blood pressure in the white man. Vegetable fat has a significant positive correlation with potassium and a negative correlation with triglycerides, systolic blood pressure, and cholesterol/HDL cholesterol in the white man. Polyunsaturated fatty acids have a significant positive correlation with potassium and a negative correlation with triglycerides and cholesterol/HDL cholesterol in the white man. If the ratio of cholesterol to HDL cholesterol is used as a method of predicting CHD,<sup>26</sup> the effect of polyunsaturated fatty acids on the cholesterol/HDL cholesterol in the white man is in agreement with Turpeinen.<sup>8</sup>

Stanton et al<sup>27</sup> showed that coffee drinking is positively correlated with age, serum cholesterol, and triglycerides and reflects a way of living that is also correlated with certain CHD risk factors. Our study showed that caffeine has a significant positive correlation with low-density lipoprotein (LDL), cholesterol/HDL cholesterol, and LDL cholesterol/HDL cholesterol ratios in the black woman, while the correlation with diastolic blood pressure is negative in the black man (Table 1c). In the white man, however, there is a significant negative correlation of caffeine

Table 1c.—Correlation of Some Diet Components and Blood Parameters Adjusted to Age 50

Dietary Component	Blood parameters									
	Cholesterol	HDL Cholesterol	Cholesterol/HDL Cholesterol	LDL Cholesterol/HDL Cholesterol	Triglycerides	BUN	Sodium	Potassium	Systolic Pressure	Diastolic Pressure
Caffeine			BF**	BF**	WM—*			WM*		BM—*
Carbohydrates					WF*	BF—*				
Fiber					WF*				WF*	
Lactose									WM*	
Sucrose	WF*					BF—*	WF—*			BF*
Sugar	WF**				WF*	BF—*	WF—*			BM—*
Ascorbic acid	WF*		WF**	WF**	WF**	BF—*				
Folic acid			WF*	WF**	WF**					
Niacin							WM*			
Pantothenic acid					WM—*			WM**	BM—*	
Riboflavin					WM—*				BM—*	
									WM**	
Thiamin							BF*			
Alpha-tocopherol					WM—*	BF—*		WM*		
Vitamin A					WF—*		WM*			
Vitamin B <sub>6</sub>					WF*			WM*	BF**	
									BM—*	
Vitamin B <sub>12</sub>				WF—*						
Vitamin D									WM—*	

BF = Black female, BM = Black male, WF = White female, WM = White male, \* = Significant at the 0.05 probability level, \*\* = Significant at the 0.01 probability level, — = Negative correlation.

†The other dietary components studied but not specifically listed are: alanine, arachidonic acid, arginine, aspartic acid, Beta carotene, cystine, fructose, glucose, glutamic acid, glycine, histidine, isoleucine, leucine, linoleic acid, linolenic acid, lysine, maltose, methionine, myristic acid, oleic acid, palmitic acid, palmitoleic acid, pectin, phytylalanine, proline, serine, stearic acid, threonine, tryptophan, tyrosine, and valine.

with triglycerides and a positive correlation with potassium.

Using regression analysis, we found that, with increasing age, the white woman has more total protein in her diet than do the black woman and the black and white men; this is also reflected in the amino acid composition of her diet. As she ages, the black woman consumes more vegetable than animal protein. In the white man, total dietary protein has a significant negative correlation with serum triglycerides and a positive correlation with serum potassium and systolic blood pressure. On the other hand, there is a positive correlation of total dietary protein with diastolic blood pressure and cholesterol/HDL cholesterol in the black woman. There is a significant negative correlation of animal protein with systolic blood pressure in the black man; however, this correlation is positive in the white man. While Hunter<sup>6</sup> and Olson et al<sup>28</sup> indicated that there may be a relation between animal protein and serum cholesterol, we found no correlation between dietary protein and serum cholesterol.

We found that, in both the black and white women, intake of vegetables and fruits increases with age, as indicated by a significant increase in their dietary fiber, pectin, fructose, and glucose. Even though Wright et al<sup>11</sup> feels that high-fiber diet lowers

mean blood pressure level, it was found that fiber has a positive correlation with systolic blood pressure only in the white woman. In addition, fiber has a positive correlation with triglycerides in the white woman.

Although it is not significant, there is an indication that black and white men as well as black women eat less as they grow older. This decrease is reflected by their caloric and total carbohydrate intake. On the other hand, the caloric intake of the white woman does not change with age, and in addition, there is a significant increase in the total dietary sugar consumption. However, there is a significant decrease in the dietary sucrose consumption in the white man. Calories have a positive correlation with cholesterol and triglycerides in the white woman, a negative correlation with the cholesterol/HDL cholesterol ratio, and a positive correlation with sodium and potassium in the white man (Table 1a). Caloric intake has no correlation with the measured blood parameters in the blacks. Total sugar has no significant correlation with the measured blood parameters in the blacks. Total sugar has no significant correlation with the measured blood parameters in the men, but it has a significant negative correlation with blood urea nitrogen (BUN) in the black woman and a positive correlation with cholesterol and tri-



Table 2.—Summary of the Number of Statistical Correlation Coefficients of the 73 Dietary Components with Blood Parameters Significantly Different from zero

Race & Sex	Serum Cholesterol	Serum HDL Cholesterol	Cholesterol/HDL Cholesterol	LDL Cholesterol/HDL Cholesterol	Serum Triglycerides
BF	1	0	3	2	1
BM	0	1	0	0	0
WF	13	0	2	4	16
WM	0	0	11	0	19

Race & Sex	BUN	Serum Sodium	Serum Potassium	Systolic Pressure	Diastolic Pressure
BF	7	8	3	0	3
BM	1	2	2	24	5
WF	1	3	2	1	0
WM	2	13	24	26	1

BF = Black female, BM = Black male, WF = White female, WM = White male

glycerides and a negative correlation with sodium in the white woman. There is a significant positive correlation of total sucrose with diastolic blood pressure and a negative correlation with BUN in the black woman, a negative correlation with diastolic blood pressure and a negative correlation with sodium in the white woman, and a positive correlation with sodium in the white man. In the white woman the intake of dairy products increased, which was reflected by a significant increase in lactose and calcium. Dietary lactose was found to have a significant positive correlation with systolic blood pressure in the white man (Table 1c).

There was a significant increase in the levels of vitamins A, B, and C, biotin, folic acid, pantothenic acid, magnesium, zinc, molybdenum, and potassium in the black as well as the white women as they grew older. In addition, niacin, riboflavin, thiamin, vitamin B<sub>12</sub>, calcium, phosphorus, cobalt, manganese, and selenium were significantly increased in the white woman. Vitamin A was significantly increased in the black man and vitamin D in the white man. There is a significant negative correlation of vitamin A with triglycerides and vitamin D with diastolic blood pressure in the white woman and man respectively (Table 1c). Abboud<sup>15</sup> stated that there is a relationship between sodium intake and hypertension; however, our study found that dietary sodium has a significant correlation with systolic blood pressure only in the white man (Table 1c). Dietary potassium has a significant negative correlation with systolic blood pressure in the black man. In addition, copper has a significant negative correlation with both systolic and diastolic blood pressure in the black man (Table 1b). There is a significant positive correlation between calcium, phosphorus, magnesium, and molybdenum with triglycerides, and iron has a negative correlation with serum triglycerides in the white woman. Molybdenum has a significant positive corre-

lation with serum cholesterol in both the black and white women. Chromium has a significant positive correlation with LDL cholesterol/HDL cholesterol in the black woman, while it has a significant positive correlation with cholesterol/HDL cholesterol in both the black woman and white man. A significant negative correlation of vitamin B<sub>12</sub> to LDL cholesterol/HDL cholesterol was observed in the white woman. Dietary chromium, iron, zinc, and potassium have been found to influence the level of serum triglycerides, while chromium also influences the serum potassium level in the white man (Table 1b).

Blood urea nitrogen is affected by dietary alpha-tocopherol in the black woman. In contrast to the finding of Bates et al<sup>29</sup> that vitamin C has an effect on HDL cholesterol level, our study showed no significant correlation. Folic acid has a positive correlation with LDL cholesterol/HDL cholesterol, triglycerides, and cholesterol/HDL cholesterol in white women. Pantothenic acid and riboflavin were shown to affect the systolic blood pressure in the black man, while riboflavin affects the systolic blood pressure and serum triglyceride level in the white man.

A significant correlation between dietary components and systolic blood pressure was found primarily in men, while a significant correlation between dietary components and serum triglycerides was found only in whites (Table 2). Even though HDL cholesterol has been related to the prevention of CHD,<sup>25</sup> it was found that, with the exception of palmitoleic acid in the black man, the dietary components studied do not have a correlation with HDL cholesterol.

## Summary

It was found that dietary cholesterol has no correlation with serum cholesterol. However, it does have a significant negative correlation with diastolic blood pressure and a positive correlation with systolic blood pressure in black and white men, respectively. Caf-

feine and sucrose have a significant negative correlation with diastolic blood pressure in the black man; however, sucrose and total protein have a significant positive correlation with diastolic blood pressure in the black woman. Dietary sodium and lactose have a significant positive correlation with systolic blood pressure in the white man; however, dietary potassium has a significant negative correlation with systolic blood pressure in the black man. Of all the dietary components measured, only dietary copper is found to have a significant correlation with both systolic and diastolic blood pressure in the black man. Dietary fiber has a significant positive correlation with systolic blood pressure in the white woman.

In general, dietary components that have a significant correlation with blood pressure are more prevalent in men than in women. Of the 78 dietary components studied, only 5 (biotin, fish fat, iodine, starch, and vegetable protein) were found to have no significant correlation with the measured blood parameters. □

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Only one rule in medical ethics needs concern you — that action on your part which best conserves the interests of your patient.

— Martin H. Fischer



# An Analysis of Petitions for Court Commitment to Psychiatric Care Filed in Tulsa County

JOHN F. GAJDA, MA

**An increase in the number of patients committed to Oklahoma public psychiatric hospitals by the civil courts is perpetuating the demand for hospital care as the mental health system moves toward treatment in the local community. Meeting the needs of these court-committed patients in the community is a critical barrier to the success of deinstitutionalization in the mental health system.**

**T**he number of individuals admitted to Oklahoma public psychiatric hospitals has been on a decline for decades. There is some evidence, however, that in the eighties the decline has flattened. Admissions may indeed be gradually increasing. For Oklahoma State fiscal years 1980 through 1984, which include a five-calendar-year period (July 1, 1979 to June 30, 1984), overall admissions to public psychiatric hospitals increased from an FY80 level of 8,379 to an FY84 level of 9,254.<sup>1-5</sup>

The implications of this five-year trend are more pronounced when admissions are categorized by type of hospital commitment (Table 1). During each of these five fiscal years, voluntary self-referrals for hospitalization were the largest admission category, but during this period voluntary referrals decreased as a percentage of total admissions from 58.1% in FY80 to 45.0% in FY84. During the same time period, civil-court commitments for hospitalization were the second-largest admission category. Civil-court commit-

ments increased, however, as a percentage of total admissions from 29.4% in FY80 to 41.8% in FY84.

One conclusion is indisputable. In Oklahoma the courts are a major gatekeeper for our public psychiatric hospitals. The demand for hospitalization from civil courts has become a significant force shaping Oklahoma's public mental health delivery system.

Deinstitutionalization is at a critical point in Oklahoma. The expanding system of community mental health care has reduced voluntary admissions to public psychiatric hospitals by providing treatment in local communities. Continued movement to a community-based mental health delivery system, however, is contingent on meeting the needs of the civil-court-committed patient in the community. Problems encountered in other states, which have caused some to question the concept of deinstitutionalization, highlight the importance of developing adequate community programs for all patients before hospital populations are reduced. Development of

Table 1. — Type of Hospital Admission

	FY80	FY81	FY82	FY83	FY84
Admissions	8,379	7,038	8,538	9,254	9,252
Voluntary self-referrals	58.1%	54.1%	57.0%	50.4%	45.0%
Civil-court commitments	29.4%	34.0%	33.4%	36.1%	41.8%
Other admissions	12.5%	11.8%	9.6%	13.5%	13.2%

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**Table 2. — Petitions Filed in Tulsa County Probate Mental Health Court: Long-Range Trend**

1969	363
1970	402
1971	361
1972	351
1973	374
1974	437
1975	486
1976	484
1977	475
1978	514
1979	508
1980	538
1981	617
1982	620
1983	542

community programs in Oklahoma is currently focused on the voluntary patient. The needs of the involuntary patient must also be addressed in order to decrease the demand for institutional care from civil courts.

As an important first step toward meeting the needs of court-committed patients, both planners and service personnel need a clearer description of these patients. Unfortunately, a minimum of information is currently available. The purpose of this study is to begin closing this information gap.

## Methodology

A longitudinal examination of all civil petitions in Tulsa County for commitment to psychiatric care was conducted. Aggregate yearly totals were gathered from 1969, and monthly totals were gathered from 1978. Detailed data were collected from individual Tulsa County Mental Health Probate records for all

petitions filed during a 48-month period from October 1, 1979, to September 30, 1983. The Examiners Certificate, which is completed by members of the examining commission appointed by the court to evaluate the mental state of individuals allegedly requiring treatment, was the primary source of information. At times, when the Examiners Certificate did not contain needed information, secondary source documents, such as petitions or other reports in the court files, were used. A total of 2,333 individual court records were examined.

## Findings

**Long-range trends.** In the 15-year period from 1969 to 1983, there was a gradual but steady increase in the number of petitions for commitment that were filed in Tulsa County (Table 2). In recent years, however, the rate of growth in the number of petitions filed has decreased and appears to have stabilized.

A certain portion of the long-range growth can be attributed to an increase in population. From 1970 to 1980 the Tulsa County population increased 17.65%.<sup>6</sup> However, the number of petitions filed increased 33.8%. Other factors which may have contributed to the increase include sociodemographic shifts in the population, programmatic changes within the mental health delivery system, and altered perception of statutes by the judiciary and law enforcement. The impact of any of these factors is difficult to assess. Actual changes in statute also influence petitions, but the only major change occurred in 1980 after most of the growth had occurred.

**Seasonal trends.** During the six calendar years from 1978 through 1983, an average of 46.4 petitions were filed each month (Table 3). Monthly totals range from a low of 25 petitions filed in September 1978 to

**Table 3. — Petitions Filed in Tulsa County Probate Mental Health Court: Six-Year Monthly Totals**

	1978	1979	1980	1981	1982	1983
January	32 ( 6.2%)	29 ( 5.7%)	46 ( 8.6%)	51 ( 8.2%)	51 ( 8.2%)	51 ( 9.4%)
February	30 ( 5.8%)	26 ( 5.1%)	47 ( 8.7%)	45 ( 7.3%)	60 ( 9.7%)	33 ( 6.1%)
March	58 (11.3%)	49 ( 9.6%)	45 ( 8.4%)	62 (10.0%)	67 (10.8%)	56 (10.3%)
April	47 ( 9.1%)	43 ( 8.5%)	45 ( 8.4%)	44 ( 7.1%)	46 ( 7.4%)	36 ( 6.6%)
May	45 ( 8.8%)	41 ( 8.1%)	47 ( 8.7%)	46 ( 7.5%)	41 ( 6.6%)	51 ( 9.4%)
June	51 ( 9.9%)	50 ( 9.8%)	44 ( 8.2%)	48 ( 7.8%)	56 ( 9.0%)	55 (10.1%)
July	41 ( 8.0%)	47 ( 9.2%)	56 (10.4%)	59 ( 9.6%)	45 ( 7.3%)	54 (10.0%)
August	66 (12.8%)	54 (10.6%)	54 (10.0%)	54 ( 8.7%)	58 ( 9.4%)	52 ( 9.6%)
September	25 ( 4.9%)	42 ( 8.3%)	37 ( 6.9%)	69 (11.2%)	63 (10.2%)	43 ( 7.9%)
October	44 ( 8.6%)	44 ( 8.7%)	47 ( 8.7%)	38 ( 6.2%)	38 ( 6.4%)	41 ( 7.6%)
November	47 ( 8.4%)	44 ( 8.7%)	38 ( 7.1%)	43 ( 7.0%)	48 ( 7.7%)	36 ( 6.6%)
December	32 ( 6.2%)	39 ( 7.7%)	32 ( 5.9%)	58 ( 9.4%)	47 ( 7.6%)	34 ( 6.3%)
TOTALS	514	508	538	617	620	542

Percentages indicate portion of each year's petitions filed in each month.



Table 4. — Source of Referral for Petition

Source of Referral	N	%
Family member	981	42.0%
Law enforcement	656	28.1%
Self	357	15.3%
Physician	287	12.3%
District attorney	32	1.4%
Other	18	.8%
Unknown	2	.1%
	2,333	

Table 5. — Sex of Petition Subjects

Sex	N	%
Male	1,482	63.5%
Female	840	36.0%
Unknown	11	.5%
	2,333	

Table 6. — Age of Petition Subjects

Minimum age	14 years
Maximum age	94 years
Mean age	35.8 years
Median age	32 years
Modal age	24 years

Table 7. — Marital Status of Petition Subjects

Marital Status	N	%
Single	792	33.9%
Unknown	498	21.3%
Married	449	19.2%
Divorced	382	16.4%
Separated	121	5.2%
Widowed	91	3.9%
	2,333	

a high of 69 petitions filed in September 1981.

If petitions were filed with equal frequency throughout the year, one would expect that  $\frac{1}{12}$ , or 8.3%, of each year's petitions would be filed in any given month. This is not the case. Although monthly trends vary from year to year, there are certain patterns that stand out. During the months of March and August, a high number of commitment petitions are filed. During the winter months of November, December, and January, fewer petitions are filed, but during the early spring months of March and April, and the late summer months of July and August, disproportionately large numbers of petitions are filed.

Table 8. — Number of Children of Petition Subjects

Number of Children	N	%
None	780	33.4%
1	338	14.5%
2	264	11.3%
3	264	7.5%
4	112	4.8%
5	46	2.0%
6	31	1.3%
7	18	0.8%
8	5	0.2%
10 or more	6	0.3%
Unknown	559	24.0%
	2,333	
Mean number of children	1.4	
Median number of children	1	
Modal number of children	0	

**Petitioners.** Family members were the source of the greatest number of referrals for commitment petitions. They filed 42% of all petitions (Table 4). The next largest referral source was law enforcement, which initiated 28.1% of the petitions. Self-referrals were the third largest source, accounting for 15.3% of petitions filed.

The large number of petitions filed by family members is not surprising. Frequently the courts are the last resort for families with mentally ill relatives. The large number of petitions filed by law enforcement is consistent with the social control functions of commitment laws. The relative frequency of self-referrals for court commitment, however, is astonishing, as the concept of a voluntary action and a court commitment would appear on the surface to be inconsistent.

**Subjects of petitions.** *Sex:* The subject of a petition is more likely to be male than female. Men outnumber women by nearly a 2 to 1 margin (Table 5). This prevalence of men needs to be contrasted to the overall county population, which is only 48.2% male and 51.8% female.<sup>7</sup>

*Age:* The subjects of petitions range in age from a low of 14 years to a high of 94 years (Table 6). The average age was 35.8 years. The modal age was 24 years. Subjects are thus a relatively young group, 50% being below 32 years of age. The age of most subjects falls into the range ascribed to the young adult chronic population. It is of concern that so many of these individuals are in the early adult stages of their lives, supposedly one of their most productive periods.

*Marital status:* Only 19.2% of the subjects were married (Table 7). Most were either single, separated,

Table 9. — Race of Petition Subjects

Race	N	%
White	1064	45.6%
Unknown	836	35.8%
Black	397	17.0%
Indian	15	0.6%
Other	12	0.5%
Spanish surname	9	0.4%
	2,333	

divorced, or widowed and thus had few family resources.

**Children:** Given the small number of married individuals, it is not surprising to find that the average number of children reported by the subjects was 1.4 (Table 8). Most frequently, subjects reported having no children. This is another indication that these individuals have few family resources to whom they can turn in times of crisis.

**Race:** Information in the records indicated that 45.6% of the subjects were white, 17.0% were black, and only 0.6% were American Indian (Table 9). It is difficult to evaluate this information because racial data were not available in 35.8% of the records reviewed. The overall Tulsa County population, however, is 85.1% white, 9.20% black, and 4.05% Indian.<sup>7</sup> Certainly, based on overall population, blacks appear to be overrepresented among petition subjects and Native Americans are underrepresented.

**Employment:** More than 27% of petition subjects were unemployed. (Table 10). Of those who indicated they were working, most were employed in low-skill professions. Subjects of petitions are unlikely to be economically secure.

**Education:** Over 28% of the petition subjects reported not having graduated from high school and relatively few had college degrees (Table 11). Educational attainment was relatively low, concomitant with low economic status.

**Diagnosis:** The examining commission determined that 47.7% of the subjects had a primary diagnosis of schizophrenia (Table 12). The next largest grouping, which includes 10.1% of the individuals examined, were those individuals with a primary diagnosis of drug or alcohol abuse. Of the individuals examined, 21.6% had an unknown or unspecified psychotic diagnosis. Experienced clinicians would estimate that most subjects suffer from schizophrenia. The large number with drug or alcohol problems is inconsistent with the commitment statutes, since drug or alcohol abuse alone was not grounds for involuntary commitment during the years studied.

**Disposition of petitions. Type of trial:** Only 1.4% of petition subjects requested a jury trial (Table

Table 10. — Occupation of Petition Subjects

Occupation	N	%
Unknown	558	23.9%
Unemployed	547	23.4%
Laborer—unskilled	542	23.2%
Other	215	9.2%
Laborer—skilled	189	8.11%
Unemployed—housewife	94	4.0%
Professional or managerial	74	3.2%
Trades or craftsman	62	2.7%
Retail or sales	52	2.2%
	2,333	

Table 11. — Education of Petition Subjects

Education	N	%
8th grade or less	221	9.5%
9th-11th grades	440	18.9%
High school or equivalent	629	27.0%
Some post-high school	309	13.3%
College graduate	114	4.9%
Some graduate education	11	1.2%
Graduate degree	28	1.2%
Unknown	581	24.9%
	2,333	

Table 12. — Examiners Primary Diagnosis

Diagnosis	N	%
Schizophrenia	1,113	47.7%
Unknown or undetermined	505	21.6%
Affective disorder	169	7.2%
Alcohol abuse	154	6.6%
Organic disorder	132	5.7%
Personality disorder	93	4.0%
Drug abuse	81	3.5%
Adjustment disorder	79	3.4%
Anxiety disorder	5	0.2%
Disassociative disorder	2	0.1%
	2,333	

Table 13. — Type of Commitment Hearing

Type	N	%
Before judge	2,290	98.2%
Jury trial	32	1.4%
Unknown	11	.5%
	2,333	

13). Although these individuals may request a jury trial, few exercise their right.

**Findings:** Only a little more than 25% of the petitions filed are dismissed (Table 14). Of those individu-



Table 14. — Court Disposition

Disposition	N	%
Committed to state hospital	1,609	69.0%
Dismissed	588	25.2%
Committed to local general hospital (see Table 16)	112	4.8%
Committed to outpatient care	16	.7%
Unknown	8	.3%
	2,333	

Table 15. — Type of Commitment for Those Committed

Type of Commitment (3 categories from Table 14)	N	%
Involuntary	1,383	79.6%
Voluntary	354	20.3%
	1,737	

Table 16. — Local General Hospital  
Involuntary Commitments

Hospital (Third Category in Table 14)	N	%
Saint John's	61	54.5%
Saint Francis	30	26.8%
Hillcrest	13	11.6%
Osteopathic	4	3.6%
Other	2	1.8%
Unknown	2	1.8%
	112	

Table 17. — Length of Stay for Those  
Committed to State Hospital

Length of Stay (First Category in Table 14)	N	%
2 weeks or less	164	11.7%
2 weeks 1 day to 1 month	279	19.9%
1 month 1 day to 2 months	485	34.6%
2 months 1 day to 3 months	225	16.0%
3 months 1 day to 4 months	104	7.4%
4 months 1 day to 5 months	53	3.8%
5 months 1 day to 6 months	33	2.4%
6 months 1 day to one year	54	3.9%
Greater than one year	5	.4%
	1,402*	

\*This information available on only 1,402 commitments out of 1,609.

als committed by the court, most go to state hospitals. Although the option is permitted, only a small number of persons are committed to local general hospitals, and even fewer are committed to outpatient treatment.

**Type of commitment:** Of the 1,737 individuals committed, over 20% are voluntary commitments (Table 15). The large number of individuals who "volunteer" to be committed by the courts is noteworthy.

**Local hospital commitments:** Although most individuals committed by the courts are sent to public psychiatric hospitals, a small number are committed to local general hospitals for treatment (Table 16). Of the 112 individuals committed to local general hospitals, nearly half were committed to Saint John's Hospital. About a quarter were committed to Saint Francis Hospital.

**Length of stay.** Of the 1,609 individuals who were committed to a public psychiatric hospital, information on the length of stay in the hospital was available for 1,402 individuals (Table 17). Median length of stay was between one and two months. Once committed by the court, individuals tend to stay in the hospital for an extended period of time. Only 19.0% stay one month or less.

## Discussion

From these data a composite of the typical individual for whom commitment to public psychiatric care is sought in Tulsa County can be created. Most likely the individual is a man in his 30s. He is manifesting a serious mental disorder, most likely schizophrenia. He is unemployed or employed in a low-skill profession. He lacks an extensive social support system, as he is not married and has few, if any, children. His level of education attainment is low. Once a petition is filed against him, he is likely to be committed to a public psychiatric hospital, and once in the hospital is likely to remain there a significant amount of time.

Other studies that have examined characteristics of the court-committed patient have focused on a narrower population than that considered in this study. Most studies are limited to those individuals committed to and currently confined in a hospital.<sup>8-11</sup> One study examined records for individuals who were evaluated for commitment, including those not committed as well as those committed, using a small sample from this population.<sup>12</sup> Where comparable characteristics were examined, the findings from the 2,333 records examined in Tulsa County are consistent with other studies.

The one characteristic that is inconsistent in the literature is the number of men vs the number of women in the committed population. In other studies, the distribution has been close to a 50-50 split. Some

studies have found more men and some have found more women. The most comparable study, which considered all individuals evaluated for commitment, found the highest percentage of men, 58%. This figure remains lower than the 63% men found in Tulsa County.

In comparison to the entire state of Oklahoma, Tulsa County admissions to public psychiatric hospitals include a much larger percentage of civil-court-committed individuals. Civil-court commitments are in fact the largest category for Tulsa County admissions and have averaged over 60% of hospital admissions during the past five fiscal years.<sup>1-5</sup> It is difficult to compare the prevalence of civil commitments for either Oklahoma or Tulsa County to other states, however. Wanck, in a review of involuntary admission rates in thirteen states over a number of years, concluded that state laws significantly influence involuntary admission rates and directly affect clinical work in state psychiatric hospitals.<sup>13</sup> Involuntary admissions were found to range from 8.7% to 97.3% of all admissions in the states studied. It is impossible to say that commitments in Tulsa County are either high or low. The number of commitments is a reflection of the nature and current application of commitment laws in Oklahoma.

The court-committed patient is difficult to treat and presents a challenge to the community mental health system. Meeting the challenge will require a realignment of community intervention strategies to reflect the needs of this population. The need for early intervention with the escalating numbers of patients

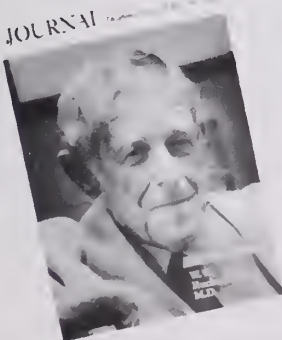
who ultimately become the subjects of commitment petitions must be addressed. Intervention by mental health professionals in the courts must increase. Community treatment programs, especially those serving the acutely ill, must be expanded. All community programs and staff treating court-committed patients must be flexible and creative.

If the emphasis in Oklahoma on local treatment of the mentally ill is to continue, this challenge must be met. □

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John F. Gajda, MA, is the executive director of the Tulsa Mental Health Council, Inc., and is the member of the Association of Mental Health Administrators.



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## Agent Orange

The Agent Orange Outreach Committee, composed of Vietnam veterans and practicing physicians, continues to examine the scientific literature and inform those concerned with the health implications of toxic chemical exposure.

No study to date has been able to demonstrate the absence of a toxic effect for dioxin. Background epidemiological studies do not provide clinical case definitions for the physician. Since this is a serious public health dilemma, it seems prudent to regard Vietnam veterans who served in the Vietnam theater as dioxin exposed, thus potentially at risk. Because there is no definitive, simple test for this toxic chemical, a history of exposure remains the only tool available to the clinician. These exposed individuals

should be encouraged to have regular medical check-ups and to follow their physician's advice concerning risk-reducing life-style improvements — such as avoiding smoking and getting, proper diet, exercise, and rest. Until the clinical risks are clearly known, vigilance is warranted, especially for telltale signs of cancer and cardiovascular and gastrointestinal disorders.

The Agent Orange Outreach Committee maintains a confidential self-registration program for the veteran and a clinical record that the physician may use. We are interested in collecting clinical information independently for study purposes. If you would like clinical references or other information, call Jerry Nida, MD, at (405) 271-4194. □

DISEASE	August 1985	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	1	10	6	16
CAMPYLOBACTER INFECTIONS	33	222	129	—
ENCEPHALITIS, INFECTIOUS	2	21	17	19
GIARDIA INFECTIONS	36	181	154	—
GONORRHEA (Use ODH Form 228)	1186	8614	8382	10240
HAEMOPHILUS INFLUENZAE INVASIVE DISEASE	10	143	128	—
HEPATITIS A	25	317	304	331
HEPATITIS B	13	139	118	177
HEPATITIS, NON-A NON-B	2	44	32	—
HEPATITIS UNSPECIFIED	7	57	75	139
MEASLES (RUBEOLA)	0	1	8	163
MENINGITIS, ASEPTIC	16	84	64	113
MENINGITIS, BACTERIAL (non-meningococcal, non H. Influenzae)	4	48	34	38
MENINGOCOCCAL INFECTIONS	1	21	23	24
PERTUSSIS	28	140	213	98
RABIES (Animal)	14	79	84	138
ROCKY MOUNTAIN SPOTTED FEVER	6	64	98	108
RUBELLA	0	1	0	1
SALMONELLA INFECTIONS	53	248	249	282
SHIGELLA INFECTIONS	48	179	126	215
SYPHILIS (Use ODH Form 228)	22	134	130	125
TETANUS	0	0	1	0
TUBERCULOSIS	19	172	147	208
TULAREMIA	1	12	16	21
TYPHOID FEVER	0	0	2	3

Diseases of Low Frequency	Total to Date This Year	
ACQUIRED IMMUNE DEFICIENCY SYNDROME	8	
BRUCELLOSIS	4	
LEGIONNAIRES DISEASE	7	
MALARIA	2	
REYE SYNDROME	2	
TOXIC SHOCK SYNDROME	11	
<b>RABIES</b>		
BECKHAM	Skunk	1
CADDO	Skunk	2
CRAIG	Cat	1
CRAIG	Skunk	1
CHEROKEE	Bat	1
CREEK	Skunk	2
GARFIELD	Bat	2
LINCOLN	Skunk	1
MAYES	Skunk	1
MCCURTAIN	Skunk	1
SEMINOLE	Cat	1

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## AMA issues guidelines for patients with AIDS antibodies

Guidelines for people at low risk of acquiring AIDS who have positive test results for HTLV-III antibody have been published in the *Journal of the American Medical Association (JAMA)*. The most stringent of these is that they should not donate blood, sperm, or body organs. Low-risk individuals are defined as those with repeated positive results who are not members of known risk groups, have no signs or symptoms of immune deficiency disease, and have normal results on physical and laboratory examination. The report is from the AMA Council on Scientific Affairs.

Tests for antibody to HTLV-III are now routinely used to screen donated blood, and all blood that is antibody-positive is discarded. The report notes that some false-positives will occur, and that when results from the enzyme-linked immunosorbent assay (ELISA) are uncertain, additional testing should be performed using the Western blot test. More true positives are expected to occur in persons from high-risk groups.

"The clinical significance of a positive ELISA test result on a single serum sample from an asymptomatic donor not belonging to any AIDS risk group is unknown," the report points out. "Ultimately all positive reactors will be referred to practicing physicians (who) will be expected to determine the significance

of a positive test result, offer sagacious medical counseling on a fatal and incurable disease, and do follow-up studies on a disease that has an incubation period of up to five years."

The report includes nine recommendations for low-risk individuals with repeated positive test results. These guidelines were developed at a consensus conference convened by the Association of State and Territorial Health Officials in March 1985. Low-risk patients should be advised that (1) the risk of developing AIDS is small, based on a positive antibody test alone; (2) they should not donate blood, sperm, or body organs; (3) with no known risk factors, a broad restriction on sexual relations is unwarranted, but advice should be individualized; (4) regular sexual partners should be tested for antibody to clarify true positive status; (5) pregnancy need not be postponed, although individual circumstances should be assessed; (6) physicians and dentists should be informed about the positive test results; (7) there is no need for restrictions on employment, education, or other social contacts; (8) additional counseling or referral is available; and (9) they should seek medical follow-up assessment within six months to identify any potential changes in medical status or recommendations.

The report also includes recommendations for individuals considered to be at high risk for AIDS. These are persons with known risk of exposure to HTLV-III, or at high risk of acquiring or transmitting the virus, including all men who have had sexual contact with another man, intravenous drug users, hemophiliacs, and other persons who have had sexual contact with someone with known or suspected exposure to HTLV-III. Recommendations for these persons include stricter precautions regarding body fluids (exchanged through intimate sexual contact or by sharing toothbrushes, razors, needles, or other implements that could become contaminated with blood); six-month medical evaluations with attention to AIDS-like symptoms; and screening of sexual partners and of children born to women at high risk. The council notes that most information to physicians about positive antibody tests has focused only on high-risk groups. ☐

## August Life Members from Tulsa, Guymon, Broken Arrow

Five Life Memberships were approved by the Oklahoma State Medical Association's Board of Trustees at their August meeting.

The new Life Members are Elvin L. Buford, MD, Guymon; Harold W. Frieze, MD, Broken Arrow; and Robert T. Cronk, MD, Robert L. Imler, MD, and Dean C. Walker, MD, Tulsa.

To be eligible for a Life Membership, an OSMA member must meet one or more of the following qualifications: (1) Be retired from the active practice of medicine due to ill health or age; (2) Be engaged in the active practice of medicine for fifty years or more; (3) Be seventy years of age or older. ☐



## Tulsa medical students win \$33,000 in TCMS scholarships

Thirty-two Tulsa area medical students have been named recipients of educational assistance awards from the Scholarship Fund of the Tulsa County Medical Society (TCMS). The total value of the awards is \$33,000, and the individual cash grants range from \$500 to \$1,500. The awards are for the 1985-86 school year.

Rollie E. Rhodes, Jr., MD, TCMS president, said the \$33,000 in awards was the largest annual distribution in the 62-year history of the scholarship fund.

The fund was established by the TCMS as a separate non-profit organization in 1962 to provide financial assistance to deserving medical students from Tulsa County. Since that time it has steadily grown through gifts and bequests from physicians and others, and from monies raised by the TCMS Auxiliary. Several scholarships are named for the donor, or were created in memory of a deceased physician or other individual.

The recipients, all residents of Tulsa County, are enrolled at the University of Oklahoma College of Medicine in Oklahoma City, the University of Oklahoma Tulsa Medical College, Oral Roberts University

School of Medicine, and Johns Hopkins Medical School.

The Dr O. C. Armstrong Memorial Awards, established by the Tulsa family practitioner who died in 1981, went to W. Todd Brookover, Dale E. Dautenhahn, Kevin W. Hargrove, Jeffrey L. Herring, Pamela L. Kimbrough, Ruth A. Weesner, Michael A. Weisz, and Mark A. Smothers.

The Dr Anna Luvern Hays Memorial Awards, funded by bequests from the late Tulsa pediatrician, were given to Lynn A. Miller, Scott S. Young, Stephen R. Lester, Jamie L. Maher, Gerald J. McNulty, and Steven Mareburger.

Recipients of the Dr William R. R. and Ruth G. Loney Memorial Awards were Dr Mark S. Brown, Michael A. Cromer, and Jay A. Flaming. These scholarships were established in memory of Tulsa obstetrician and gynecologist William R. R. Loney, MD, who died in 1966, and his wife, Dr Ruth G. Loney, who passed away in 1980. Both were widely known for their civic and cultural activities in Tulsa.

Robert J. Hernandez was given the Dr Maxwell A. Johnson Memorial Award, named for the Tulsa urologist and medical leader who died in 1971.

The Glass-Nelson Clinic Memorial Award, established in memory of deceased partners of that group practice clinic, was given to Jeff McIlroy.

The Martha Jane and Richard Jackson Memorial Awards went to Charles H. Hill, Gregory R. Holt, Lisa A. Hudson, Steven D. Kick, Martina J. Ritchey, and Kevin M. Dukes. Mrs Jackson, who died in 1981, was a former Sinclair Oil Company employee who created the awards in appreciation of physicians' services to herself and her late husband.

Recipients of the Dr Frank L. and Jessie O. Flack Memorial Awards were Kenneth W. Veteto, Brian D. Whitson, and Kevin W. Kilimann. A surgeon and medical leader who died in 1963, Dr Flack was widely known for developing professional services in low-income areas of Tulsa. Mrs Flack, a Tulsa civic leader, died in 1983.

The Auxiliary to Tulsa County Medical Society Awards, funded by grants from the organization of physicians' spouses, were given to Patricia A. Ledwig and Linda D. Swartz.

Robert T. Spencer received the Dr John G. Matt Memorial Award, created in memory of the late colon and rectal surgeon.

The Glenda Ann Cale Memorial Award, established in memory of a 23-year-old Southwestern Bell Telephone Company worker, was given to Jean M. Kay. □

  
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## OSMA Auxiliary Confluence held in OKC October 23-24

In the audience at the Park Suite Hotel, top, are OSMAA President Mary Ann Deen (center foreground) and Immediate Past President Camille Harrison (far right).

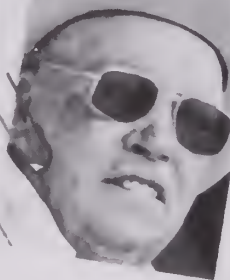
Above, addressing the group, is Susan Paddock, Ada, chairman of the highly successful Medi-File card program.

At left is guest speaker J. Darrel Smith, MD, medical director of the OSMA Physician Recovery Program.

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## By the numbers: AMA reports trends in medical schools

First-time enrollment in United States medical schools has decreased for the third year in a row, while the numbers of female applicants, students, and graduates continue to increase. The trends are reported in the 85th annual medical education issue of the *Journal of the American Medical Association (JAMA)*.

Anne E. Crowley, PhD, of the Office of Educational Directories at the AMA, observes that although total enrollment is down, the number of applicants to medical schools increased by more than 700 during 1984-1985, reversing the decreases of the past few years. She suggests this may be explained in part by the practice of deferred acceptance; some medical schools allow accepted students to delay enrollment. Of the 35,944 applicants, 17,194 students were accepted by at least one school for enrollment in fall 1984.

"For 1984-1985, women accounted for 35% of applicants, 33% of the entering class, 32% of total enrollment, 30% of MD graduates, and 25% of residents in graduate medical education programs," Crowley says. She notes that seven years ago, more than one third of the specialties had no women in training,

but in 1984 there were women residents in all programs except vascular surgery.

The numbers and percentages of medical students from minority groups have not changed much during the last few years, according to the report. Total minority enrollment in medical schools for 1984-1985 was 15.7% — 5.5% blacks, 5.0% Asians or Pacific Islanders, 1.9% Puerto Ricans, 1.6% Mexican-Americans, 1.4% other Hispanics, and 0.4% American Indians or Alaskan natives.

Approximately 2% of students enrolled in US medical schools are non-US citizens, Crowley notes. Seventy-five percent of these students come from 18 Far Eastern countries, 25 countries in Central America, and 20 European countries.

The total number of students expected to graduate in 1985 was estimated at 16,347, and 58% of these had accepted residency positions in the primary care specialties. The total number of residents in training continues to increase; in September, 1984, there were 75,125 residents on duty in 96% of accredited programs. More than two-fifths were in family practice, internal medicine, or pediatrics.

The report also includes financial information for

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## ER admissions under DRG plan could produce "dumping"

Hospitals with large numbers of emergency department admissions, especially Medicare patients, may face financial losses resulting from the prospective payment system, according to a recent report.

Eric Munoz, MD, MBA, and colleagues at Long Island Jewish Medical Center studied the effect of diagnosis-related group (DRG) payments on emergency-department-generated admissions for both Medicare and an all-payer system during 1983-1984. Their findings showed that Medicare patient deficits measured \$2,363,163 while all-payer patients showed a net profit of \$4,267,859 when costs were used to compute expenses. When charges were used as a measure of expense, all clinical departments showed losses for both Medicare and all-payer patients, registering \$12,895,033, and \$15,553,893 respectively.

Researchers also found that implementation of federalized DRG reimbursement rates increased losses from 1983 to 1984 and that reductions in outlier reimbursement (10%) and teaching costs (25%) caused revenues to drop, which added to these losses.

"Strategically, the institution will face several alternatives to deal with an unprofitable emergency department population," the researchers say in the *Journal of the American Medical Association*

(*JAMA*). They recommend promoting more efficient, less costly practice patterns, although these will be difficult to implement in the short term. The researchers also suggest that, although it is ethically displeasing to physicians and the public, hospitals may restrict or redirect admission of financially risky patients (a practice known as "dumping"). They point out that public hospitals are most susceptible to this practice. A third strategy proposed by the researchers is that of negotiating some subsidy for the higher costs of such patients from the payers of medical care.

The researchers conclude, "The final outcome will be determined by a complex combination of forces on physicians and administrators, which include philosophic and financial realities at each hospital, in addition to their immediate competitive environment." □

## Hypothermia in the elderly less common than suspected?

Hypothermia, or abnormally low core body temperature, may be less common in older persons than previously thought, according to a report in the *Journal of the American Medical Association (JAMA)*.

Leonard Keilson, MD, MPH, of Maine Medical Center, Portland, and colleagues studied core body temperature in 97 elderly and 20 young subjects by measuring both urine temperature and oral temperature first thing in the morning. The elderly volunteers were recruited from rural and urban housing projects and from a general internal medicine clinic in Maine.

"The present study failed to confirm the prevalence of low core temperatures in three elderly populations studied by means of urine temperature measurement," the researchers say. "Furthermore, no statistically significant differences were found between elderly study subjects and a youthful population."

The researchers note that their study results contrast with those from a similar, larger study conducted in Britain in 1972. While none of the Maine subjects had urine temperatures below 35.5° C (96° F), 10% of the British subjects did. In addition, more of the Maine subjects were poor or chronically ill, groups thought to be of higher risk for hypothermia. Maine subjects had urine temperatures that were on average .3° C warmer than British subjects, and oral temperatures that averaged .19° C warmer. The differences may be partly attributed to differences in the methods used, the researchers say. □

## By the numbers (continued)

the 1983-1984 fiscal year. Tuition and fees for medical schools increased by 13% from the previous year but remained a small fraction of total revenues. Revenue from service income has nearly tripled between the years 1970-1971 to 1983-1984, from 12% of total revenue to 33%. Conversely, revenue from federal sources represented 44% of the total in 1970-1971, but less than 25% in 1983-1984. Financial assistance to medical students increased 10% from 1982-1983, with the most notable increases in so-called "loans of last resort," which increased by more than half. "The average education debt of graduating seniors in 1983-1984 was \$26,883, an increase of more than 12% from the previous year. More than one third of graduates had debts of more than \$30,000."

The report notes that during the 1984-1985 school year, 58,767 full-time faculty provided instruction for 67,090 students enrolled in medical schools. Crowley adds, "It should be noted that medical school faculties were also responsible for providing some instruction for 68,800 other health professions students, for conducting continuing education courses for practicing physicians, and for medical research, as well as for the care of patients in the teaching hospitals." □

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## DEATHS

### **Meredith M. Appleton, MD** **1908 - 1985**

Meredith M. Appleton, MD, a Buffalo, Okla, native, died Saturday, September 7, in Oklahoma City. The 1934 graduate of the University of Oklahoma School of Medicine was a urologist and a Diplomat of the American Board of Urology. He was also a Fellow of the International College of Surgeons and professor emeritus at the OU School of Medicine. During World War II he served with the US Army in the European Theatre, attaining the rank of Lieutenant Colonel.

### **Robert Alan Northrup, MD** **1925 - 1985**

OSMA Life Member Robert A. Northrup, MD, died in Tulsa on September 8 at the age of 59. Dr Northrup, a Tulsa native, was graduated from the University of Oklahoma School of Medicine in 1948 and served with the US Air Force from 1948 to 1952. In 1953 he began his Tulsa practice in obstetrics and gynecology.

### **Carl H. Bailey, MD** **1909 - 1985**

Carl H. Bailey, MD, a family practitioner for over 35 years, died in Tulsa on September 9. Born in Fort Worth, Tex, he earned his medical degree at the University of Oklahoma in 1933. From Stroud he moved to Eufaula and then to Davenport, where he was in practice for five years before his retirement and move to Tulsa twelve years ago.

### **In MEMORIAM** **1985**

<i>Owen L. Hill, MD</i>	<i>January 15</i>
<i>Earl M. Lusk, MD</i>	<i>January 30</i>
<i>Larry L. Lowery, MD</i>	<i>February 12</i>
<i>Harry Wilkins, MD</i>	<i>February 14</i>
<i>William H. Buchan, MD</i>	<i>February 15</i>
<i>Austin H. Bell, MD</i>	<i>February 23</i>
<i>Glen W. McDonald, MD</i>	<i>February 25</i>
<i>E.C. Lindley, MD</i>	<i>March 1</i>
<i>Charles W. Freeman, MD</i>	<i>March 5</i>
<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>Forest R. Brown, MD</i>	<i>March 19</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Hanna B. Karam, MD</i>	<i>March 28</i>
<i>Ernest S. Kerekes, MD</i>	<i>June 8</i>
<i>L. Chester McHenry, MD</i>	<i>June 8</i>
<i>Seigul J. Polk, MD</i>	<i>June 10</i>
<i>Murray M. Cash, MD</i>	<i>June 11</i>
<i>Franklin Jesse Nelson, MD</i>	<i>June 13</i>
<i>Robert L. Kendall, MD</i>	<i>June 21</i>
<i>Marion K. Ledbetter, MD</i>	<i>July 3</i>
<i>James Floyd Moorman, MD</i>	<i>August 8</i>
<i>Oscar R. White, MD</i>	<i>August 14</i>
<i>Maurice P. Capehart, MD</i>	<i>August 29</i>
<i>Meredith M. Appleton, MD</i>	<i>September 7</i>
<i>Robert A. Northrup, MD</i>	<i>September 8</i>
<i>Carl H. Bailey, MD</i>	<i>September 9</i>
<i>Hugh B. Spencer, MD</i>	<i>September 13</i>
<i>Bernice E. McCain, MD</i>	<i>September 14</i>
<i>Robert Ray Rupp, MD</i>	<i>October 2</i>

### **Hugh Burns Spencer, MD** **1917 - 1985**

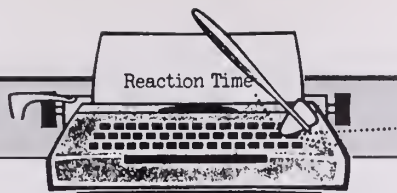
Tulsa pediatrician Hugh B. Spencer, MD, a Life Member of the OSMA, died on September 13. The Hamilton, NY, native received his medical degree from Indiana University School of Medicine in 1950 after serving during World War II as a Captain in the US Army. He established his medical practice in Tulsa in 1953 and retired in 1983.

### **Bernice Eugenie McCain, MD** **1911 - 1985**

OSMA Life Member Bernice E. McCain, MD, Shawnee pathologist, died September 14. Dr McCain, who was born in Hope, Ark, was graduated from the University of Arkansas School of Medicine in 1946. Prior to her move to Shawnee in 1967, she held positions in Pine Bluff, Ark, and El Dorado, Ark. A member of the College of Pathologists and the Southern Medical Association, she retired in 1974.

### **Robert Ray Rupp, MD** **1927 - 1985**

Tulsa County general practitioner Robert R. Rupp, MD, died October 2 of an apparent heart attack. He was 58 years old. A native of Kansas City, Mo, Dr Rupp earned his medical degree from the University of Oklahoma College of Medicine in 1956. Prior to that he had spent three years in the US Army medical corps in Germany. Dr Rupp was a member of the American Academy of Family Physicians.



## **"Now now reflex" observed in Claremore, says case report**

*To the editor:* After reading your recent editorial in the JOURNAL ["Now Now: The Premorbid Reflex," Sept 85], I would like for you to know there are many of us in the practice today who have the exact same feelings as you do, and because of our particular personalities we have been subjected to the now, now reflex.

I, too, have been befuddled by my inability and ineffectiveness as a persuader. I have been seeing our government becoming more and more oppressive every day. I see our people becoming more greedy and selfish each day. These characteristics are being fanned and promoted by our legal profession. We seem impotent to do anything about it.

I sincerely hope that through all of the trials and tribulations that life is now presenting, doctors will

maintain their high ethical standards. I hope that those of our colleagues who have the ability to influence others will soon grasp the full meaning of what we "now, nowers" have been saying and influence the others before it is too late.

Our society can not continue to exist without honest, moral people with a high ethical standard of living. Dr Johnson, you can see that you are not the only now, now reflex solicitor in the world; there are many of us. We receive our impetus to continue whenever we see that there are others, like yourself, fighting the same battles we are involved in. So keep up the good work.

*Larry J. Hrdlicka, MD  
Claremore*

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**Communicable and Infectious Diseases.** Edition nine. Edited by Paul F. Wehrle and Franklin H. Top, Sr. Saint Louis: C.V. Mosby Company, 1981. Pp 792, \$59.50.

This edition of *Communicable and Infectious Diseases* continues the tradition established with the publication of the first edition forty years ago. Dr Wehrle is now listed first as editor. The eighth edition was reviewed in the JOURNAL of the Oklahoma State Medical Association, 72:318, 1979. It is a popular, outstanding, and respected textbook. The editors have assembled a group of seventy-five contributors, generally well-known experts in their respective areas, to give an authoritative and comprehensive presentation of the subject. The text is organized into seventy-four chapters, with the discussions of specific diseases arranged alphabetically. Each disease is covered in a standard fashion. Most chapters have an extensive, up-to-date bibliography, and there are good photographs. As in previous editions, the various appendices are useful, as is the glossary designed for paramedical personnel.

As pointed out in the preface, infectious diseases continue to represent a major health problem in all countries despite the change in prevalence of individual diseases and their relative importance. New chapter topics in this edition include botulism, tapeworm infections, and legionellosis. Other chapters have been revised. This edition is dedicated to Dr Maxwell Finland.

The appearance of this edition after an interval of some five years is welcomed.

Harris D. Riley, Jr., MD  
Oklahoma City

**Theories of Fever from Antiquity to the Enlightenment.** (*Medical History*, Supplement No. 1). Edited by W. F. Bynum and V. Nutton. London: Wellcome Institute for the History of Medicine, 1981. Pp 154, \$16.00.

*Theories of Fever from Antiquity to the Enlightenment* is an assemblage of seven essays that were delivered at a meeting of the Wellcome Institute for the History of Medicine in June 1980. As stated in the introduction, the essays in this collection "are put forward both as an insightment to a further study of this vast topic and as an attempt to bring some of the approaches of a modern medical historian to bear on a few aspects of a tradition that stretch for over two millennia from Hippocrates to the nineteenth century."

The seven essays are thoroughly researched and well presented in the context of the various and specific theories of fevers. The periods included range from the case notes in epidemics written in about 400 BC to the study of fevers in Britain between 1760 and 1820. Professor Andrew Cunningham in one article reflects on the opposing views on the cause and management of fevers in Edinburgh during the seventeenth century. This reflects the political and other disputes between Sydenham's medical approaches and the health implications of Newton's natural laws.

Other chapters discuss therapeutic conflicts in Britain during the eighteenth century, Dutch and German concepts of fever, and the impact of the great plagues on the development of scientific thought.

These essays are primarily intended for the medical historian. However, the physician interested in the influence of epidemic disease on public health concepts will find something of value here.

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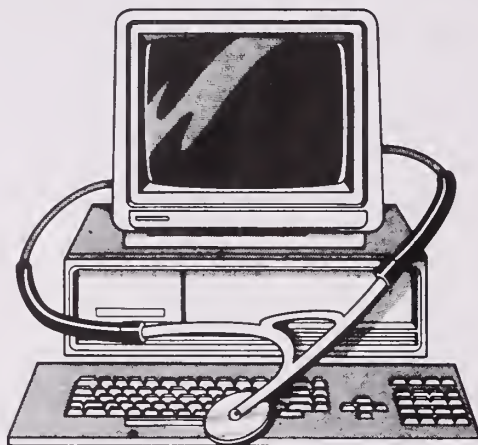
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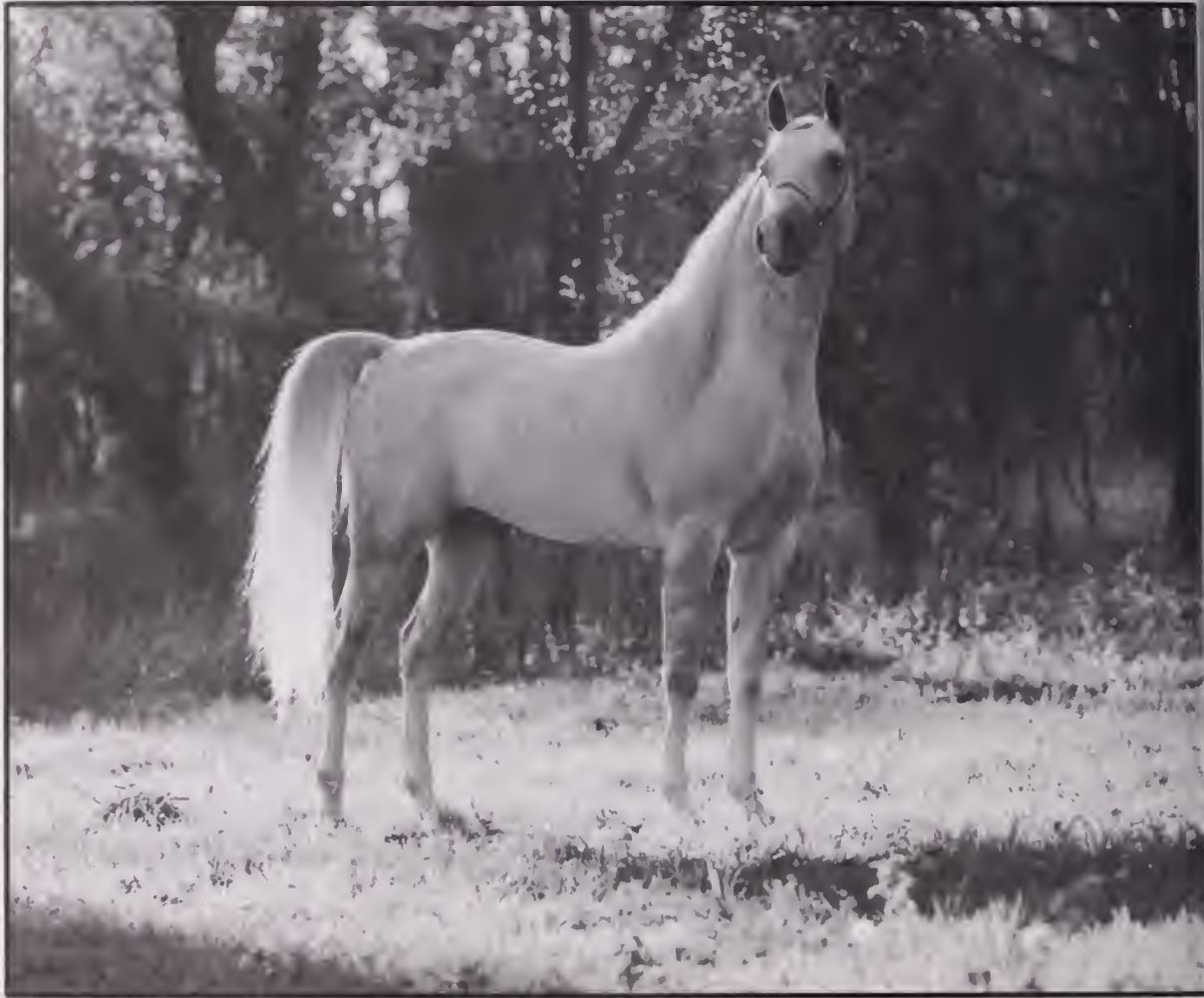
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### References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. *Am J Cardiol* 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. *Chest* 78 (July suppl):234-238, 1980.

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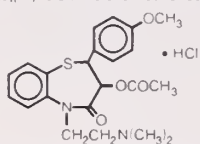


## PROFESSIONAL USE INFORMATION



### DESCRIPTION

**CARDIZEM** (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)-one, 3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride, (+)-*cis*-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

### CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

**Mechanisms of Action.** Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm. CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina. CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

**Hemodynamic and Electrophysiologic Effects.** Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

**Pharmacokinetics and Metabolism.** Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

### INDICATIONS AND USAGE

1. Angina Pectoris Due to Coronary Artery Spasm. CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).

2. Chronic Stable Angina (Classic Effort-Associated Angina). CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

### WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

### PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

**Pediatric Use.** Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%),

headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LOH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

### OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levaterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD<sub>50</sub>'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD<sub>50</sub>'s in these species were 60 and 38 mg/kg, respectively. The oral LD<sub>50</sub> in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

### DOSAGE AND ADMINISTRATION

**Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm.** Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

#### Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely administered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

### HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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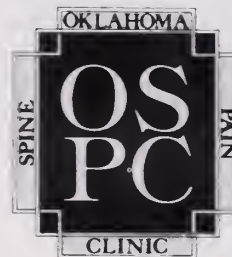
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## INDEX TO ADVERTISERS

Allied Nursing Care .....	12A
Anesthesiology Department, OUHSC .....	10A
The Arthritis Clinic .....	28A
Ayerst Laboratories ( <i>Inderal LA</i> ) .....	6A-8A
Bank of Oklahoma .....	15A
The Cardiac Surgeons of Oklahoma City, Inc. ....	23A
Central Oklahoma Ambulatory Surgical Center, Inc. ....	30A
Comprehensive Medical Office Management, Inc. ..	438
Computers Plus Healthcare .....	428
Curtis 1000 Information Systems .....	14A
Dista Products ( <i>Keflex</i> ) .....	4A
Dorsey Pharmaceuticals ( <i>Hydergine LC</i> ) .....	9A, 10A
Edmond Medical Plaza .....	433
For Doctors Only .....	30A
C. L. Frates & Co., Inc. ....	435
Frontier Federal Savings & Loan .....	2A
Glass-Nelson Clinic .....	26A
Harsha Orthopedic, Inc. ....	30A
Marion Laboratories ( <i>Cardizem</i> ) .....	19A, 20A
McAlester Clinic .....	26A
Medical Arts Clinic of Ardmore .....	27A
Medical Arts Laboratory .....	29A
James B. Morris II & Associates .....	10A
Oakdale Farm .....	11A
Oklahoma Allergy Clinic .....	24A
Oklahoma City Clinic .....	IFC
Oklahoma Hand Surgery Center, Inc. ....	29A
Oklahoma Lung Function Laboratory .....	29A
Oklahoma Urology Center .....	30A
Orthopedic & Arthritis Center .....	27A
Orthopedic Associates .....	28A
OSMA Council on Member Services .....	18A
PLICO .....	21A
Professional Billing Associates .....	437
Professional Office Management .....	1A
RediCare Clinics, P.C. ....	430
Rehabilitation Institute of Oklahoma .....	432
Roche Products, Inc. ( <i>Dalmane</i> ) .....	IBC, BC
Shawnee Medical Center Clinic, Inc. ....	25A
Southern Plains Medical Center Clinic, Inc. ....	25A
Timberlawn Psychiatric Hospital .....	24A
Tulsa Adjustment Bureau, Inc. ....	427
The Upjohn Company ( <i>Motrin 800</i> ) .....	5A
Willow View Hospital .....	22A
Windy Meadow Farm .....	16A, 17A

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**MEM•BER•SHIP** . . . with the unification of these three syllables lies the very essence of any organization. For without membership, there is no organization. As members of the Oklahoma State Medical Association Auxiliary, we are an acknowledged factor in the health care equation. The medical auxiliary, hand in hand with the OSMA, has the ability and organizational structure to lead its members in these times of change and must be a unified voice to effect desired health care solutions. Success in reaching our common goals demands a strong commitment derived from a genuine concern for our fellow man and the health care environment in which we share.

Our unification and organized action is needed now more than ever before, as the traditional role of medicine changes so rapidly that we can hardly answer the difficult questions even our friends ask. At no time in the history of medicine have we seen such revolutionary changes taking place in the health care industry. As DRGs, PPOs, HMOs, and various other alternative systems of health care delivery become more and more common . . . as competition for patients increases . . . as the threat of malpractice litigation becomes more prevalent . . . as new technology leads to ethical questions never before considered . . . today's physicians see the practice of medicine changing before their very eyes. As these changes accelerate, pressures on the physician increase . . . as well as on the physician's spouse and family. The profession is being shaped by forces far beyond the control of the individual physician. It's no wonder we all want to close our eyes and think more pleasant thoughts. However, it is time to realize that unification and involvement is the only way to influence the forces that demand so much of the profession.

Legislation, increased competition, and defined benefit health policies instead of cost-plus policies are going to change the way physicians will practice medicine and their families will live in the future. If we are going to have any say in this matter, it is imperative that we become involved. As one of the

AMA lobbyists told the delegates to the AMAA Annual Meeting in Chicago last June, the legislators hear from their constituents about how unreasonable medical costs are, but they do not hear the other side of the story from the individual physicians and their families. Which would you listen to . . . shouts or silence?

Perhaps the negative professional image we hear about is no more than receiving inadequate credit for doing good as suggested by the AMAA president, Mary Kay McPhee. In the AMA's 1984 public opinion poll, most consumers felt positive about their own physician, but very negative towards the profession as whole. With you and your spouse's involvement, we can turn this image around.

Our medical auxiliary offers a volunteer organization of dedicated individuals committed to improving their communities and the lives of their neighbors. Our auxiliaries are volunteers willing to take responsibility, to participate, to share, and to give. We give but we also receive; our rewards are many and include valued friendships made while seeking solutions to the common objective of improving the health and quality of life for all Americans through community health programs, legislative action, and fund raising for medical schools and students.

Physicians, please encourage your spouses to find out what their county auxiliary is doing about community health projects, pending legislation, and public awareness of the medical profession's concern for quality health care. If your county does not have an organized auxiliary, your spouse can be a member-at-large in the state and national auxiliary and receive informational publications, invitations to meetings, and can have the opportunity to make a difference in the future you share. The medical auxiliary has the means, the cause, and the strong federation support. All we need is the spouse in your house to join the Auxiliary!!

*Julie Weedn (Mrs Robert)  
OSMAA Membership Chairman*



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## THE LAST WORD

■ **Sir Thomas Bagley-White of London, England**, currently the assistant director of the British Health Service was the featured speaker at the Oklahoma Hospital Association convention in Tulsa November 6-8. His topic was "A Different Medical Society: Does It Work?" Bagley-White, a former practicing physician, has been a medical administrator for the past fifteen years. For some fourteen years he was one of the personal physicians attending the royal family. Oklahoma was one of only two states being visited by Sir Thomas during this trip to the US.

■ **Newman Memorial Hospital in Shattuck** has recently announced plans to build a \$200,000 facility as an extension of its wellness program. The project, a joint venture with the city of Shattuck, includes space for aerobics classes, weightlifting, racquetball, and banquet facilities. The plans were announced after the hospital finished its fiscal year with a budget surplus.

■ **HERO: An Oral History of the Oklahoma Health Center**, a 430-page chronicle by Robert C. Hardy, executive of the Oklahoma Health Sciences Foundation, was released earlier this month. *HERO*, in the words of its author, "gives you behind-the-scenes insight into what went on, a close-up look at the Oklahoma Health Center, warts and all." The book may be ordered directly from the Oklahoma Health Sciences Foundation, 314 N. Robinson, #A, Oklahoma City, OK 73102, (405) 271-4778. Single copies are \$35 plus \$3 mailing and handling.

■ **Language deficits are reduced more rapidly** and more completely than are cognitive deficits in patients with subcortical stroke, according to a study in the October *Archives of Neurology*. Davida Fromm, MS, of the Western Psychiatric Institute and Clinic in Pittsburgh, and colleagues prospectively and systematically studied 16 patients, noting patterns of lesion and impairment. "Recovery was most dramatic within the first six to eight weeks after onset," they say.

■ **Remember, a one-year subscription to the Oklahoma State Medical Association JOURNAL** is only \$10 (in the US). With a Christmas gift subscription from you, friends and relatives with an interest in Oklahoma medicine will be able to read about it firsthand every month. Send their names and addresses with your check to the OSMA JOURNAL, 601 Northwest Expressway, Oklahoma City, OK 73118.

■ **Grady County area teachers are attending** classes on health — offered free of charge by the nursing, technical, and medical staffs of Grady Memorial Hospital. "Health Care — Just for Teachers" will be held throughout the school year and will deal with specific health issues such as basic first aid for the playground, substance abuse awareness, and childhood diseases.

■ **The California Medical Association (CMA)** has endorsed an initiative filed by the Tort Reform Coalition for the state's June 1986 ballot. The initiative would limit a defendant's liability to his proportionate share of noneconomic damages. The CMA has pledged \$100,000 to help qualify the initiative, provided that other members of the coalition steering committee meet their initial share of the expense. The Tort Reform Coalition includes the CMA, the Association for California Tort Reform, the California Hospital Association, the California Chamber of Commerce, the California Manufacturers Association, the California Supervisors Association, and the League of California Cities, as well as insurance associations and other organizations.

■ **Carl R. Bogardus, Jr., MD, Oklahoma City** radiologist, was recently elected to the Board of Chancellors of the American College of Radiology at the ACR's annual meeting in Montreal. At the same meeting, Don A. Wilson, MD, Edmond, was named a Fellow of the ACR.

■ **Permanent eyelash loss can follow pigment** implantation, known as eyelid tattooing, designed to replace the need for daily application of cosmetic eyeliner, according to a report in the October *Archives of Ophthalmology*. "Our study suggests that systemic exposure to the implant material is possible and offers explanations for permanent eyelash loss, which we have seen following this procedure," say David T. Tse, MD, and colleagues from the University of Iowa in Iowa City. The pigment suspension is composed of 98% iron and 2% titanium, they add. Offering editorial criticism, Richard L. Anderson, MD, of Salt Lake City, says, "The sensational promoting of eyelid tattooing makes one wonder about the direction of our specialty and the value of the many years spent in professional training." He says the procedure may finally prove to be safe and useful but emphasizes that it has not been studied scientifically and therefore should not be recommended widely.

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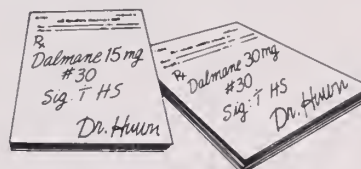
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**References:** 1. Kales J, et al. *Clin Pharmacol Ther* 12 691-697, Jul-Aug 1971. 2. Kales A, et al. *Clin Pharmacol Ther* 18 356-363, Sep 1975. 3. Kales A, et al. *Clin Pharmacol Ther* 19 576-583, May 1976. 4. Kales A, et al. *Clin Pharmacol Ther* 32 781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc* 27 541-546, Dec 1979. 6. Dement WC, et al. *Behav Med*, pp 25-31, Oct 1978. 7. Kales A, Kales JD. *J Clin Psychopharmacol* 3 140-150, Apr 1983. 8. Tennant FS, et al. Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21 355-361, Mar 1977.



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**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

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**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, ataxia, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, tinnitus, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions (e.g., excitement, stimulation and hyperactivity).

**Dosage:** Individualize for maximum beneficial effect. Adults: 30 mg usual dosage, 15 mg may suffice in some patients. Elderly or debilitated patients: 15 mg recommended initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



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# JOURNAL

## Oklahoma State Medical Association

DECEMBER 1985

VOL. 78, No. 12

### EDITORIAL

Not For Christmas Only ..... 439

MARK R. JOHNSON, MD

President's Page ..... 440

ELVIN M. AMEN, MD

### SCIENTIFIC

Botulism — A Case Report ..... 441

JOE D. RIDDLE, MD

Airborne Bacterial Contamination from Patients  
on MA-1 Volume Ventilators ..... 444

JOYCE E. THOMPSON, D.J. FLOURNOY, PHD

Comparison of Rubazyme with Haemagglutination  
Inhibition Test for Determination of Antibody to  
Rubella Virus ..... 448

S.M. HUSSAIN QADRI, PHD; GERTRUDE P. CHAN, MD

### SPECIAL

HERO Is Here ..... 451

ROBERT C. HARDY

Early-Day Physician ..... 453

E.L. CALHOON, MD

### NEWS ..... 457

State doctors elected to key offices . . . AIDS strategies get  
AMA's attention . . . Planned Parenthood publishes book . . .  
Genes can predispose an individual to alcoholism . . . Tulsa  
and OKC labs share in vitro fertilization efforts . . . Teen  
alcohol use predicts later abuse . . . Congressman addresses  
problems with further Medicare cuts . . . AMA schedules  
meeting on impaired health professionals . . . "The Ghost of  
Freedoms Past"

### INDEX TO 1985 CONTENTS ..... 469

### DEPARTMENTS

State Department		Index to	
of Health	455	Advertisers	26A
Deaths	467	Instructions	
In Memoriam	467	for Authors	26A
Miscellaneous		Auxiliary	27A
Advertisements	467	The Last Word	28A

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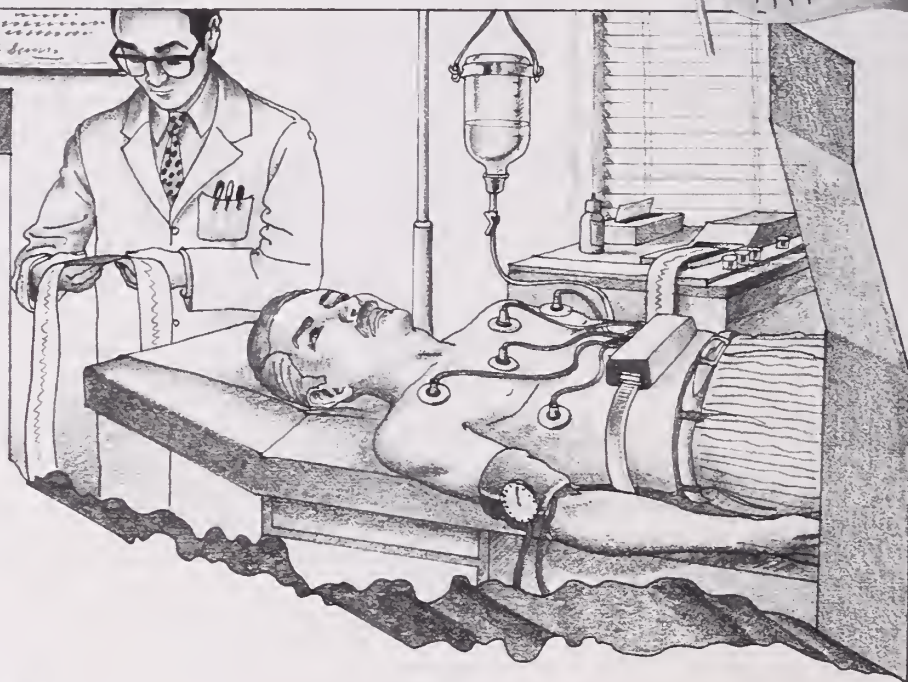
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# OKLAHOMA MEDICINE TODAY

## Reducing the stress in stress tests for coronary artery disease



## When exercise may be contraindicated

Many patients with chest pains cannot exercise adequately. Yet traditional stress tests require patients suspected of having coronary artery disease to perform treadmill or bicycle exercise involving vigorous leg motions.

Recognizing the inherent limitations of such testing, researchers at the Veterans Administration Medical Center and the University of Oklahoma Health Sciences Center joined in efforts to develop an alternative method which would be equally useful in evaluation while eliminating some of the disadvantages.<sup>1,2</sup>

## Investigating epinephrine infusion

Investigational studies were undertaken on the basis of the physiologic response to intravenous epinephrine infusion in patients with chest pains. Arterial blood pressure, systolic time intervals and ECG measurements were recorded before, during and after the infusion.

## Encouraging results to consider

While the patient sample was statistically small, the results were significant. The predictive value of a positive test for coronary disease was 100%, while the predictive value of a negative test for excluding coronary disease was 80%.<sup>2</sup>

Additionally, none of the patients suffered complications from the epinephrine infusion, nor were there signs of agitation or anxiety during the test period.

Further, epinephrine infusion has some specific advantages: since exercise is not required, patients with pulmonary disease, neurologic defects, peripheral vascular disease or other problems precluding exercise can be tested. The patient's cooperation is not required, the equipment requirements are minimal and inexpensive and, since the patient is lying quietly during the tests, other measurements may be taken concurrently, resulting in a saving of technician time.<sup>1,2</sup>

**References:** 1. Treadmill test alternative *Diagnosis*, Jul 1983, p 11.  
2. Schechter E, Wilson MF, Kong Y-S. *Am Heart J* 105:554-560, Apr 1983.

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\*Feighner JP, et al *Psychopharmacology* 61:217-225, Mar 22, 1979

Please see summary of product information on following page.



#### LIMBITROL® ® Tranquilizer-Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of moderate to severe depression associated with moderate to severe anxiety

**Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

**Warnings:** Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

**Precautions:** Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

**Adverse Reactions:** Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

**Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

**Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

**Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

**Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

**Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

**Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

**Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

**Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

**Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Overdosage:** Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

**Dosage:** Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

**How Supplied:** Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100; Prescription Paks of 50.

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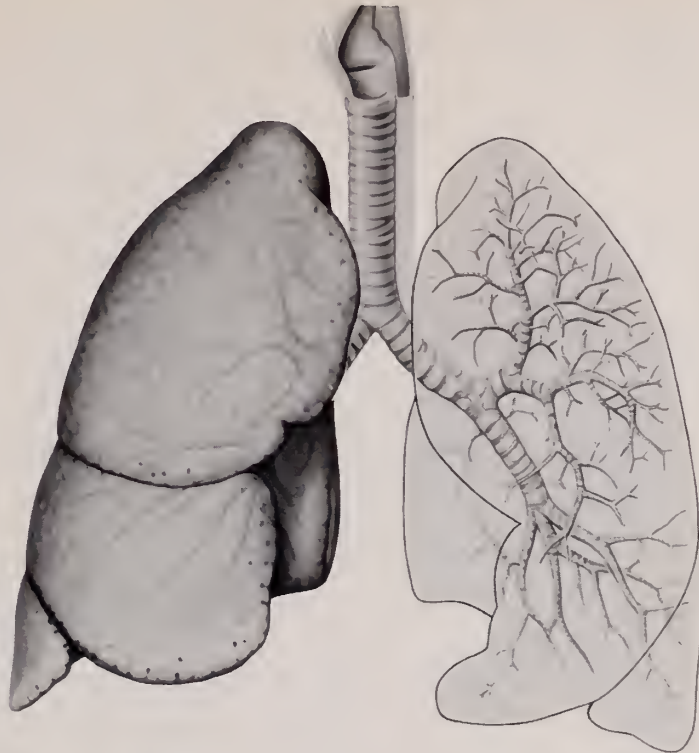
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**Brief Summary:** Consult the package literature for prescribing information.

**Indications and Usage:** Cecilor® (ceftiofur, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

**Lower respiratory infections:** including pneumonia caused by *Streptococcus pneumoniae* (Diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cecilor.

**Contraindication:** Cecilor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cecilor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics including macrolides, semisynthetic penicillins, and cephalosporins; therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, manage-

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

**Precautions:** General Precautions—In an allergic reaction to Cecilor® (ceftiofur, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids. Prolonged use of Cecilor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cecilor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because dose savings may be lower than that usually recommended. As a result of administration of Cecilor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

**Usage in Pregnancy—Pregnancy Category B—**Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cecilor® (ceftiofur, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers—**Small amounts of Cecilor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Cecilor is administered to a nursing woman.

**Usage in Children—**Safety and effectiveness of this product for use in infants less than one month of age have not been established.

**Adverse Reactions:** Adverse effects considered related to therapy with Cecilor are uncommon and are listed below.

**Gastrointestinal symptoms** occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

**Hypersensitivity reactions** have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain—**Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic—**Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

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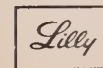
**Renal—**Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

**Note:** Cecilor® (ceftiofur, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C. cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. 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One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. **Pregnancy Category C:** There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecostasia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385



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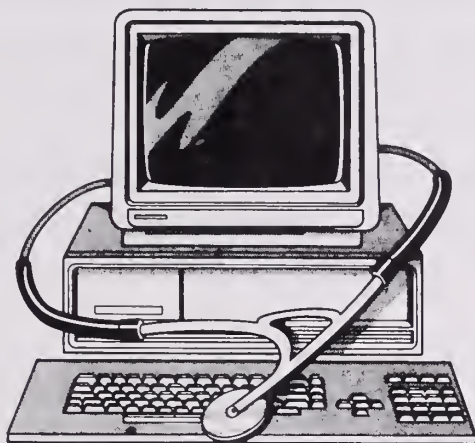
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## Not For Christmas Only

My favorite Christmas story has nothing to do with the season of Christmas. It has to do with what I perceive as the spirit of Christmas. It has to do with the meaning of life as distinguished from survival and death. It is a true story.

A patient of mine who, because of the recent death of her father had found it necessary to place her mother in a nursing home, asked if I would visit her mother and attend to her medical needs. I agreed and scheduled a visit to the home. There I met a frail, gray woman who greeted me with a welcoming smile and an outstretched hand; it was like her voice — thin and soft and warm. She had prepared her world and herself for my visit. Everything was clean and neat and dusted with the subtle fragrance of bath powder. Her hair framed a gentle countenance bejeweled with sparkling blue eyes. She answered my questions with candor and intelligence, and her memory was unimpaired, as was her sense of humor. I learned from her that she had taught school for almost fifty years. I learned from the cards standing half open and crowded on her bedside table that she was the object of many loves. Her anecdotes about the sender of each card left no doubt that she was aware of the love they symbolized.

As I was finishing my task, my new friend and patient interrupted my writing.

"Now, Doctor, would you answer a question for me?" she asked with a touch of apology in her tone.

"I'll be happy to try," I said, anticipating a request for a summary of my findings.

"Why are you doing this?" Totally devoid of rancor, her questions continued. "Do you expect me to start teaching again? To get up out of this bed, leave this place, and make some great contribution to society? To be worth something again? Why should I continue living? What is the purpose of it?"

My paltry resources left me speechless. I was embarrassed by the soundless pause held so uncomfortably in my open mouth. My response, hastily gathered from the scraps of irrelevant fact, was vacuous.

"Because your daughter wants you to be well

cared for," I explained as I began to take my leave. I felt naked as I promised to return for periodic visits.

"That's very nice of you, and I don't want you to think I'm ungrateful or unappreciative. I just can't help wondering," she replied.

It was almost a week before I found the answer to her question. A week of hearing it asked again and again. A week of searching for my own purposes, my own meaning of life, my own meaning as a physician.

On the pretense of reporting her test results, I stopped to visit my patient — the recently widowed, long-retired school teacher who had taught me, by asking the simplest question, the most profound lesson of my life.

"I found the answer to your question," I said.

She clasped my hand with both of hers. "Wonderful, Doctor. Please tell me." I knew she remembered my discomfort at the conclusion of our first visit.

"First, I want to thank you for asking. You've taught me one of the most important lessons of my life, even though you are retired from teaching," I began. She smiled expectantly. I continued.

"I am doing all of this because you are loved, not only by your daughter but by hundreds of others," I explained, waving my hand toward the cards on the table. "Furthermore, you are aware of this love and greatly enriched by it. You are a very wealthy woman in terms of life's meanings. In turn, you love many, many people. Your life is filled with loving and being loved, even more than it was the day you were born.

"So, my dear teacher, you now have as much reason for living as you had the day your life began, don't you?" I studied her face and eyes, watching for her response. Slowly her anxious expression faded, and a winsome smile surrounded her mouth.

"Yes, yes — I understand. Put that way — yes, indeed. To love and be loved — that really is what it's all about, isn't it?" She gently squeezed my hand. "Thank you so much for that, Doctor. Now I can stop wondering."

Irrespective of your religious convictions, Merry Christmas . . . for the rest of your life.

—MRJ

## PRESIDENT'S PAGE

**T**he holiday season is upon us! This is a joyous time for all, young and old alike! Sparkling lights, happy voices, jolly parties are the order of the day! Children of all ages look forward to the celebration of the day chosen to remember the birth of the Son of God!

In the midst of the merriment, let us take time to be rev-



erent and to worship our God and His Son.

Merry Christmas and a Happy New Year to all.

Sincerely,

*Elvin M. Amen, M.D.*



## Botulism — A Case Report

JOE D. RIDDLE, MD

**Despite the prevalence of the organism and the potency of the toxin, botulism remains a relatively rare disease in Oklahoma. Its rarity, however, contributes to the difficulty of diagnosing its early, nondescript symptoms.**

A twenty-three-year-old law student contracted botulism in April 1984. Intensive medical care with antiserum, mechanical ventilation, parenteral fluids, and physical therapy were successful in preventing death, but prolonged paralysis and respiratory embarrassment resulted. A persistent paralytic ileus required fluid and nutritional support. Artificial, mechanical ventilation was required for several weeks. Examination after dismissal revealed a persistent proximal muscle weakness and compromised ventilatory function, ten weeks after toxin ingestion.

### Case History

On April 7, 1984, a twenty-three-year-old female law student prepared a meal of goulash for lunch. The goulash was made from ground beef, noodles, tomatoes, and tomato juice. The tomatoes used were picked, prepared, and canned by members of her family in her hometown in Oklahoma. Some of the tomatoes were eaten directly from the jar and the rest, along with the tomato juice, were included in the goulash, which was heated for one and one-half hours but never boiled. The patient did not note any abnormality of the condition of the jars, seals, or contents.

In fact, she stated that the taste was normal. She had a second meal from the preparation later that evening.

The patient had been on a stringent weight loss diet and was on a rather strict budget. She therefore made great use of vegetables, canned in quantities by her family and brought to her apartment where she lived alone. Although several other family members had eaten from similar canned items, no other person had ingested any of the contents of the jar that later became suspect.

The following morning she awoke with "swimming" vision and vertigo. The symptoms seemed to be made worse by walking about and became less intense on sitting or lying down. She did not have a headache, fever, chill, sore throat, or earache. Her recent health history had been unremarkable and, in particular, there had been no recent history of symptoms suggesting respiratory, gastrointestinal, or urinary infection. Her symptoms prompted an examination at the Student Health Service later that afternoon. That examination disclosed no particular abnormality and she was given 50 mg of dimenhydrinate for vertigo and impending nausea.

The following morning the nausea continued, and the patient began to exhibit difficulty in walking and visual dysfunction manifested by diplopia and inability to focus. She returned to the health service and was admitted for observation.

During the next twelve hours her condition drastically worsened, with weakness progressing to paralysis in the shoulder, hip, and throat muscles.

Joe D. Riddle, MD, 1125 North Porter, #201, Norman, Oklahoma 73071.

Examination the next morning, some sixty hours after ingestion of the suspect food, disclosed divergent strabismus, slurred speech, and inability to move her extremities. Consultation and transfer to another hospital were arranged.

A history taken on admission to the second hospital disclosed the patient's prior diet history, and a tentative diagnosis of botulism was made. Examination disclosed an overweight young woman with ptotic eyes, divergent strabismus, nystagmus in all directions but worse on far lateral gaze, profound weakness of hip and shoulder muscles but relatively good strength in hand grip and foot movement, and intact memory and sensory function. She exhibited very slow, slurred speech with a gravelly voice. All speech

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## **The toxin has been lethal to all tested animals.**

---

was repeatedly interrupted by gasping respiration. Her attempt to swallow ice to relieve her dry mouth resulted in severe strangling. A gag reflex, however, was normal. Although her ptotic, divergent eyes and relaxed facial muscles gave a look of lethargy and sleepiness, she was very alert, anxious, and in absolute terror because of her rapidly deteriorating status. The vital signs showed a tachycardia and a tachypnea but no fever. There was no stiffness of the neck and no straight leg signs. Auscultation of the lungs and heart disclosed only the tachycardia. The abdomen was soft and quiet with no tenderness. The skin was moist but not clammy, and the color was normal.

Endotracheal intubation was performed, and an intravenous line was established. Laboratory test results, including arterial blood gas levels, were obtained, and a nasogastric tube was placed.

The state health department was consulted, and responses from the Centers for Disease Control (CDC) and Food and Drug Administration (FDA) were immediately forthcoming. Serum and stool samples were obtained from the patient and sent to the CDC for testing. The suspect jar and remaining tomatoes, juice, and goulash were flown directly to the FDA testing lab in Dallas for analysis.

The patient's initial  $\text{PaO}_2$  was 49 and  $\text{PaCO}_2$  was 60. Oxygen without ventilatory assistance increased

her  $\text{PaO}_2$  to 60 but increased the  $\text{PaCO}_2$  to 75. Ventilatory assistance was begun.

A computerized tomographic x-ray of the brain showed no abnormality. Tests of cerebrospinal fluid showed no cells and normal protein and sugar levels. The patient's complete blood count (CBC), urinalysis, electrolytes, and chemistries were normal. A chest x-ray was notable only because of the patient's failure to inhale deeply. Her electrocardiogram showed a tachycardia. Attempts at lavage via the nasogastric tube produced food particles.

Two vials of trivalent antitoxin arrived via emergency flight and police escort and were administered after appropriate testing for allergic response to horse serum. Administration of antibiotics was begun.

Within forty-eight hours after the antitoxin was administered, the patient began to show improvement in eye muscle function, with loss of strabismus and blurriness. Her respiratory function remained poor for several days as assayed by frequent routine measurements of tidal volume, vital capacity, negative inspiratory pressure, and minute ventilation. Consultation with a surgical subspecialist was obtained, and an elective tracheostomy was performed.

The routine measurement of vital capacity increased from a low of 100 ml upon admission to one of greater than 1200 ml shortly before extubation.

Her fluid management was made more difficult by a profound paralytic ileus that defied attempts at alleviation with gastric lavage, various cathartics, enemas, metoclopramide, and dexpantenol. Nasogastric suction, instituted upon admission, was continued for weeks. Parenteral nutrition was limited to glucose and vitamins. The patient had been on a relative fast prior to the episode, losing twenty-five pounds in the preceding two months. Ketosis was already present, and the patient continued to be overweight.

Neurological consultation and an electromyogram obtained several days after admission showed normal nerve conduction velocities and changes in amplitude on stimulation of the muscle, indicative of a myasthenic syndrome and compatible with botulism.

Progressive increase in leg and arm strength accompanied slowly increasing respiratory capability, and the patient was taken off artificial ventilation after a total of thirty-two days on the ventilator. She ate a liquid meal some twenty-eight days after her last meal, the now infamous goulash. She was dismissed from the hospital thirty-six days after admission and thirty-nine days after consuming the toxin.

At re-examination two weeks after hospital dismissal, the patient continued to show hip girdle and



shoulder muscle weakness, although she could move about with a walker. She was not dyspneic at rest, but continued to demonstrate less than normal inhalation effort and poor lung capacity.

Reports from the Centers for Disease Control revealed evidence of type A botulinum toxin in both the patient's serum and stool. The Food and Drug Administration found type A toxin in the empty tomato juice jar and in the samples of goulash. Several other samples of tomatoes and other home-canned foodstuffs showed no evidence of the toxin.

## Discussion

Botulism is a lethal illness caused by the ingestion of a most potent toxin. This toxin is produced by a spore-forming, gram-positive, rod-shaped bacterium, *Clostridium botulinum*. The toxin develops in strictly anaerobic conditions and has been lethal to all tested animals. Nine hundred and fifty molecules have been shown to be lethal for a laboratory mouse.<sup>1</sup> The toxin is irreversibly bound to motor axons, preventing release of acetylcholine and rendering the involved muscle group flaccidly paralyzed.<sup>2</sup> The spores of this bacterium are found in soils worldwide. Although various strains of the bacteria produce slightly different toxins, they are all lethal. Type A, as in this case, is the most common, but types B, E, and F have also been reported in the United States.<sup>3</sup>

Considering the prevalence of the organism, the potency of the toxin, and the widespread use of home canning in Oklahoma, it is surprising and fortunate that it remains a rare disease. Its rareness, however, makes its diagnosis more difficult. This is confounded by the initial nondescript symptoms and by the sometimes extremely long delay between ingestion of the toxin and onset of the symptoms (as long as fourteen days).<sup>2</sup> Outbreaks with a large number of cases are unusual, and individual or family occurrences are typical.<sup>4</sup> This is shown to have considerable effect on prognosis because index cases, in general, take much longer to diagnose.<sup>1</sup> Rapid diagnosis and initiation of therapy with antiserum have a significant impact on the course of the illness.<sup>5</sup> The unbound toxin is inactivated by the antiserum, and as in this case, significant amounts of unbound toxin were still in the patient's blood at least sixty hours after ingestion. Illness from type A toxin, such as this patient developed, has the most rapid onset and quickest binding of the toxin to cholinergic nerve endings in the peripheral nerve-muscle endplate synapse.<sup>1</sup> Other types may have circulating unbound toxin for several days.<sup>3</sup>

Respiratory assistance is the major reason the fatality ratios have dropped from as much as 70% in

the past to less than 10% today. Multiple problems from prolonged ventilatory assistance and lack of nutrition, however, necessitate close observation of laboratory and physical findings in the patients.<sup>6</sup>

Information for all home canners should include knowledge of the illness and proper techniques for prevention. Every home-canned item should be prepared by heating to 120°C by pressure cooker for at least thirty minutes to ensure destruction of clostridial spores, for while the bacterium is very susceptible to boiling temperatures, the spore is not. (Boiling at 100°C for 6.5 hours is necessary for total spore destruction.)<sup>1</sup> Once sealed in the anaerobic container, the surviving spores germinate to become toxin-producing organisms.

Foods that have a finished acidity pH of 4.0 or lower are very unlikely to produce a botulism toxin because of the relative hostility of the environment. However, it is important to realize that home-canned tomatoes and pickled peppers, while considered acidic, do *not* commonly attain that pH and are frequent sources of botulism.<sup>3</sup>

Boiling toxin-containing canned food for 10 to 15 minutes during the cooking process will destroy any formed toxin and render the food safe.<sup>5</sup>

Immediate consultation with ancillary services (state health department, CDC, and FDA) is mandatory to help establish the diagnosis, obtain appropriate antiserum, and prevent the development of additional cases.<sup>7</sup> □

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*Joe D. Riddle, MD, Norman, is an assistant clinical professor of medicine at the University of Oklahoma Health Sciences Center and attending physician for Central State Grif-fin Memorial Hospital's medical ward. A 1973 graduate of the University of Oklahoma, Riddle is board certified in internal medicine and a Fellow of the American College of Physicians.*

# Airborne Bacterial Contamination from Patients on MA-1 Volume Ventilators

JOYCE E. THOMPSON, D. J. FLOURNOY, PhD

This paper notes the passage of respiratory-tract pathogens from patients, through the circuitry of MA-1 volume ventilators, and finally into the surrounding atmosphere. This occurrence could be an important factor in the transmission of pathogens to patients and hospital personnel.

We have noted the passage of a stock strain of *Pseudomonas aeruginosa* ATCC 27853, from an updraft nebulizer suspension, through the circuitry of an MA-1 volume ventilator (Puritan-Bennett Corporation, Kansas City, Mo), and out the exit port of the spirometer.<sup>1</sup> These experiments took place in a laboratory setting and no patients were involved. Controversy surrounded the study because it was believed that atmospheric contamination involving patients as the contamination source would not occur in an actual hospital setting. There was also a question as to whether a patient on a volume ventilator could generate a bacteria-laden aerosol and thus contaminate the circuitry system. It is commonly accepted that ventilators without mainstream reservoir nebulizers do not generate microaerosols and are no more hazardous than breathing ambient hospital air.<sup>2</sup>

Most studies concerning infections resulting from the use of respiratory-therapy equipment have focused on the fact that ventilators, nebulizers, and humidifiers can act as primary sources of patient

contamination via bacteria-laden aerosols, presumably during inspiration (ie, the contaminated equipment was the source of infection).<sup>2-7</sup> Our study is different because we wanted to show that organisms originating directly from a patient could be expelled into the environment, thus allowing for the potential spread of pathogens to patients and hospital personnel (ie, the patient using the ventilator was a potential source of infection, while the equipment was an intermediate "host"). This study reports on atmospheric bacterial contamination from patients at this institution who were on MA-1 volume ventilators.

## Materials and Methods

Experiments were designed to determine if patient-generated organisms could be recovered from air coming from the exit ports of spirometers on MA-1 volume ventilators. Air entering the instrument was filtered; there was, however, no filter between the patient and the spirometer on the exit side.

Air was cultured using 100 mm-diameter, 5% sheep blood agar plates. The plates were taped to the bottom of the spirometer so that descending air, having passed through the ventilator, would blow on the exposed agar surface. This was depicted in an earlier report.<sup>1</sup> Plates were left on the spirometer for 60 minutes. Following exposure, the plates were incubated for 24 hours at 35°C. Colonies were then counted. Isolates were identified by conventional methods,<sup>8</sup> and in some cases API 20E® strips (Analytab Products, Plainview, NY) were used to provide additional biotyping information. Antimicrobial susceptibility testing was by disc-agar diffusion.<sup>9</sup> In some instances,

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Table 1.—Organisms Isolated from Patient Number One

Date	Culture	Isolate	Antimicrobial Susceptibilities													
			AN	AM	CB	CFP	FOX	CR	C	CL	GM	PIP	SXT	TE	TI	TM
9-14-83	Spirom	<i>Smarcescens</i>	S	R	R	S	S	R	S	R	R	—	S	S	—	R
9-14-83	Spirom	<i>Pseudomonas</i> sp	R	—	R	S	—	—	—	R	R	S	—	—	R	R
9-14-83	Spirom	<i>Pseudomonas</i> sp	R	—	S	S	—	—	—	R	R	S	—	—	S	R
10-31-83	Sputum	<i>Smarcescens</i>	S	R	R	S	—	R	S	R	R	—	R	R	—	R
12-02-83	Sputum-T	<i>Smarcescens</i>	S	R	S	—	S	R	S	R	S	—	S	R	—	S
12-02-83	Sputum-T	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S
12-08-83	Sputum	<i>Smarcescens</i>	S	R	S	S	—	R	S	S	S	—	—	—	—	S
12-08-83	Sputum	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S
12-22-83	Sputum	<i>Smarcescens</i>	S	R	S	S	—	R	S	S	S	—	S	R	—	S
1-01-84	Sputum	<i>Smarcescens</i>	S	R	S	S	S	R	S	R	S	—	S	S	—	I
1-01-84	Sputum	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S
1-06-84	Sputum	<i>Smarcescens</i>	S	R	S	—	S	R	S	R	S	—	S	S	—	R
1-06-84	Sputum	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S
1-15-84	Sputum	<i>Smarcescens</i>	S	R	S	S	S	R	S	R	S	—	S	R	—	R
1-15-84	Sputum	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S
1-29-84	Sputum	<i>Smarcescens</i>	S	R	S	S	—	R	S	R	S	—	S	R	—	R
1-29-84	Sputum	<i>Pseudomonas</i> sp	S	—	S	R	—	—	—	S	S	S	—	—	S	S
3-22-84	Spirom	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S
3-22-84	Spirom	<i>Pseudomonas</i> sp	S	—	S	S	—	—	—	R	S	S	—	—	S	R
3-23-84	Spirom	<i>Pseudomonas</i> sp	S	—	S	S	—	—	—	R	S	S	—	—	S	R
3-26-84	Spirom	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S
3-26-84	Spirom	<i>Pseudomonas</i> sp	S	—	S	S	—	—	—	R	S	S	—	—	S	R
3-26-84	Spirom	<i>Eagglomerans</i>	S	R	S	S	S	R	S	S	S	S	S	S	—	—
3-27-84	Spirom	<i>Pseudomonas</i> sp	S	—	S	S	—	—	—	R	S	S	—	—	S	R
3-27-84	Sputum	<i>Pmirabilis</i>	—	R	S	S	S	R	S	R	S	S	S	R	—	—
3-27-84	Sputum	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S
3-27-84	Sputum	<i>Smarcescens</i>	S	R	S	S	S	R	S	R	S	S	S	S	—	—
4-01-84	Sputum	<i>Smarcescens</i>	S	R	S	S	R	R	S	R	S	S	S	R	—	—
4-01-84	Sputum	<i>Pmirabilis</i>	S	S	S	S	S	S	S	R	S	S	S	R	—	—
4-01-84	Sputum	* <i>Paeruginosa</i>	S	—	S	S	—	—	—	S	S	S	—	—	S	S

**Spirom** (spirometer), **Sputum-T** (sputum trap), **S** (susceptible), **R** (resistant), **I** (intermediate), **—** (not done), **\*** (same organism from patient and spirometer), **AN** (amikacin), **AM** (ampicillin), **CB** (carbenicillin), **FOX** (cefotaxim), **CR** (cephalothin), **C** (chloramphenicol), **CL** (colistin), **GM** (gentamicin), **PIP** (piperacillin), **SXT** (sulfamethoxazole-trimethoprim), **TE** (tetracycline), **TI** (ticarcillin), and **TM** (tobramycin)

Spirom (spirometer), Sputum-T (sputum trap), S (susceptible), R (resistant), I (intermediate), — (not done), \* (same organism from patient and spirometer), AN (amikacin), AM (ampicillin), CB (carbenicillin), FOX (cefoxitin), CR (cephalothin), C (chloramphenicol), CL (colistin), GM (gentamicin), PIP (piperacillin), SXT (sulfamethoxazole-trimethoprim), TE (tetracycline), TI (ticarcillin), and TM (tobramycin)

routine sputum cultures or sputum trap cultures were also taken at the same time spirometer exit-port air was cultured. In other cases, routine sputum cultures were taken prior to exit-port sampling. The patients studied were in the Medical Intensive Care Unit at the Veterans Administration Medical Center (VAMC) in Oklahoma City. Patients were studied for several days, but it was not uncommon for some of these seriously ill individuals to die, thus preventing long-term culturing. Five patients were studied.

Identification, biotyping, and antimicrobial susceptibility test results were then compared in an effort to establish a link between organisms in the patient and those recovered from the spirometer exit port.

Quality control on the 5% sheep blood agar plates, identification, and antimicrobial susceptibility testing media yielded adequate responses.

## Results

Tables 1 and 2 note the results from studies of two patients. The most important points in Table 1 are

the occurrence of the same organism, *P aeruginosa*, from sputum and the spirometer on separate days. These isolates had identical antimicrobial susceptibility patterns and biotype numbers (API #2212004). In addition, several other gram-negative bacilli were cultured from the air exiting the spirometer. The *Pseudomonas* species isolates from the spirometer on 3-26-84 and 3-27-84 were the same biotype (API #4307725). Patient number 1 had been on the MA-1 since 8-19-83. Table 2 notes the occurrence of *Klebsiella oxytoca* isolates, with identical antimicrobial susceptibility patterns, from the patient and spirometer. *Rhodotorula rubra* (API #2670073), a red yeast, was also cultured from the spirometer of patient number 2. Patient number 2 was on the MA-1 from 3-19-84 to 4-6-84.

The number of colonies isolated from blood agar plates exposed to air exiting from the spirometer is shown in Table 3.

## Discussion

Nosocomial infections associated with respiratory



Table 2.—Organisms Isolated from Patient Number Two

Date	Culture	Isolate	Antimicrobial Susceptibilities													
			AN	AM	CB	CFP	FOX	CR	C	CL	GM	PIP	SXT	TE	TI	TM
3-19-83	Sputum	<i>K pneumoniae</i>	S	R	R	S	S	S	S	S	S	S	S	S	—	—
3-21-83	Sputum-T	<i>K pneumoniae</i>	S	R	R	S	S	S	S	S	S	S	S	S	—	—
3-21-83	Sputum-T	<i>P maltophilia</i>	R	—	R	I	—	—	S	S	S	I	S	—	R	R
3-23-83	Spirom	<i>R rubra</i>	—	—	—	—	—	—	—	—	—	—	—	—	—	—
3-24-83	Sputum	<i>E coli</i>	S	R	S	S	S	R	S	S	S	S	S	S	—	—
3-25-83	Sputum	<i>S marcescens</i>	R	R	R	S	R	R	S	R	R	R	S	R	—	—
3-25-83	Sputum	<i>E coli</i>	S	R	S	S	S	R	S	S	S	S	S	S	—	—
3-26-83	Sputum	<i>P maltophilia</i>	R	R	R	R	R	R	S	S	R	R	S	I	—	—
3-26-83	Sputum	<i>E coli</i>	S	R	S	S	S	R	S	S	S	S	S	S	—	—
3-26-83	Sputum	* <i>K oxytoca</i>	S	R	R	S	S	S	S	S	S	S	S	S	—	—
3-26-83	Spirom	* <i>K oxytoca</i>	S	R	R	S	S	S	S	S	S	S	S	S	—	—
3-27-83	Spirom	* <i>K oxytoca</i>	S	R	R	S	S	S	S	S	S	S	S	S	—	—
3-29-83	Spirom	* <i>K oxytoca</i>	S	R	R	S	S	S	S	S	S	S	S	S	—	—

Spirom (spirometer), Sputum-T (sputum trap), S (susceptible), R (resistant), I (intermediate), — (not done), \* (same organism from patient and spirometer), AN (amikacin), AM (ampicillin), CB (carbenicillin), FOX (cefoxitin), CR (cephalothin), C (chloramphenicol), CL (colistin), GM (gentamicin), PIP (piperacillin), SXT (sulfamethoxazole-trimethoprim), TE (tetracycline), TI (ticarcillin), and TM (tobramycin)

therapy equipment usually result from the inspiration of bacteria-laden aerosols by compromised patients.<sup>2-7, 10-13</sup> Contaminated aerosols result from the multiplication of organisms in moist, aerosol-producing devices such as nebulizers.<sup>2</sup> Gram-negative aerobic bacilli are the most commonly found group of contaminants. *Pseudomonas* and *Acinetobacter* species are two of the most frequently reported culprits.<sup>7, 11-16</sup> Much attention has been given to eliminating bacteria-laden aerosols, devising effective decontamination of equipment,<sup>17, 18</sup> and establishing cost-effective maintenance.<sup>19</sup> Most of the studies in this area have centered on preventing infection in patients while they are using respiratory therapy equipment.

Relatively speaking, only a little consideration has been devoted to the potential spread of pathogens from ventilated patients to nearby patients and hospital employees. Mechanically ventilated patients have higher levels of chest colonization than nonventilated patients.<sup>20</sup> Levels of greater than 100,000 organisms/ml have been reported for endotracheal secretions.<sup>10</sup> Also, the oropharyngeal colonization of patients by gram-negative bacilli increases dramatically during periods of upper respiratory tract infections.<sup>21</sup> Patients who are on ventilators for long periods thus have the potential for cultivating extremely large numbers of organisms. In one report, patients requiring long-term mechanical ventilation were studied. Patient tubings were not changed during the study. All tracheal tubes were infected by day 9; 2 to 4 days later the expiratory limbs were contaminated, and much later the inspiratory limbs were contaminated.

It was noted that, in practice, bacteria pass easily

from patients to ventilators.<sup>22</sup> We do not believe that it takes more than several hours for the expiratory circuitry of an MA-1 to become contaminated with oropharyngeal flora and/or lower respiratory tract pathogens. Igarmo et al have demonstrated the exhalation of organisms from patients on Bird Mark VIII ventilators.<sup>23</sup> However, the Bird Mark VIII ventilator does not prefilter inspired air and lacks a spirometer, thus differing considerably from the MA-1.

In a study very closely related to ours, Irwin et al showed spirometers to be an intermediate source of contamination.<sup>16</sup> Even daily sterilization of spirometers did not prevent a spirometer-induced outbreak of *Acinetobacter*. Once spread, the organisms were transmitted from person to person. The use of spirometers had to be stopped, and emphasis on hand-washing increased, before the outbreak ceased. Dyer and Peterson discovered that challenge organisms could travel 32 feet from the exhalation valve of operating IPPB equipment in an air-conditioned room.<sup>24</sup> The use of fans in intensive care units, where many compromised patients are in close proximity, could therefore be considered a dangerous practice, since air turbulence can disperse pathogens.

Our studies, along with these others, have clearly shown the potential for contamination and subsequent infection of nearby patients and hospital employees. The most obvious solution is to prevent the emission of organisms into the atmosphere. Filtration appears to be the most practical, least expensive, and least toxic (to patient) method of eliminating the emission of organisms. A good filter should trap all organisms in the air, be disposable, inexpensive, easy to install in-line, and most importantly, must not create any appreciable back pressure while in use

Table 3.—Organisms Isolated from Spirometer Air

Date	Patient	# of Colonies	Organism
9-14-83	#1	1	<i>Serratia marcescens</i>
9-14-83		8	<i>Pseudomonas</i> sp
3-22-84	#1	5	<i>Pseudomonas aeruginosa</i>
		1	<i>Pseudomonas</i> sp
	#3	2	<i>Enterobacter aerogenes</i>
	#4	2	<i>Klebsiella pneumoniae</i>
3-23-84	#1	2	<i>Pseudomonas</i> sp
	#2	1	<i>Rhodotorula rubra</i>
3-26-84	#1	1	<i>Pseudomonas</i> sp
		1	<i>Pseudomonas aeruginosa</i>
		2	<i>Enterobacter agglomerans</i>
	#2	6	<i>Klebsiella oxytoca</i>
3-27-84	#1	5	<i>Pseudomonas</i> sp
	#2	3	<i>Klebsiella oxytoca</i>
3-29-84	#5	6	<i>Enterobacter agglomerans</i>
	#2	5	<i>Klebsiella oxytoca</i>

over a period of hours. Several filters meeting most of these specifications are now on the market. If exhalation-line filters are not used, increased emphasis must be placed on the decontamination of spirometers. However, even daily decontamination was not effective in preventing a bacterial outbreak, as we have noted.

Our study has shown that organisms can pass from patients, through the circuitry of MA-1s, and finally out into the surrounding atmosphere. Our most conclusive evidence comes from patient number 1 (Table 1), with *P. aeruginosa* as the culprit. Pseudomonads are somewhat notorious in their involvement with infections during respiratory therapy. Im et al showed that pseudomonads contaminate ventilator tubing and subsequently infect patients.<sup>7</sup> Phillips and Spencer reported that *P. aeruginosa* is more likely to occur in patients with immature or debilitated body defense mechanisms.<sup>14</sup> Patient number 1 would surely fit this picture, since he was on ventilators for many months. We isolated several organisms from the exiting spirometer air and sputum of this patient. Although the antimicrobial susceptibility patterns matched up only for *P. aeruginosa*, the other organisms (*S. marcescens* and *Pseudomonas* species) were also most likely being passed from the patient and through the ventilator. It is not unusual for susceptibility patterns to change over a period of time during antibiotic chemotherapy. Often, resistant mutants are selected out.

One recent, well-publicized study has recommended changing circuitry every two days, as opposed to every day, thus reducing disposable costs considerably.<sup>19</sup> The study noted that there was no significant increase in ventilator tubing colonization during the second day. However, expiratory-phase gas was not cultured. It is therefore possible, even probable,<sup>10,20-23</sup>

that colonization on the expiratory side could be considerable. If this is confirmed, it may be necessary to reevaluate the policy of changing tubing every 48 hours. Of course, the use of filters could offset this problem and extend the use of the tubing.

We are now in the process of evaluating filters. Another study which might be appropriate in this area would be a determination of the proportion of patients shedding pathogens into the atmosphere via ventilators, with more emphasis on evaluating cross-contamination of the nearby environment. □

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# Comparison of Rubazyme with Haemagglutination Inhibition Test for Determination of Antibody to Rubella Virus

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**Rubazyme, an enzyme-linked immunosorbent assay for detecting antibodies to rubella virus, was found to be accurate, less time-consuming than similar tests, easy to perform, and economical.**

**R**ubella, more commonly known as German measles, is a benign, self-limiting viral infection in children and adults. However, for the developing fetus carried by an infected mother, results may be serious due to a high incidence of fetal anomalies. Effects of fetal infections may include congenital heart disease, cataracts or chorioretinitis, or deafness. It is therefore important to accurately determine the immune status of women of reproductive age to diagnose and confirm past exposure to rubella virus. There is a need for an assay with a low occurrence of false positive reactions in order to avoid vaccinating women who are actually susceptible to rubella infections.

The HAI test is currently the most widely accepted method for both serological diagnosis of rubella infections and determination of immune status. However, the HAI test has been found to be time consuming, labor intensive, and sometimes difficult to standardize; furthermore, interpretation of its result is somewhat subjective.<sup>1,2</sup> In addition, a small percentage of sera show residual nonspecific reactivity due to the presence of serum lipoproteins even after treatment with heparin-MnCl<sub>2</sub>, which is

being used in the serology laboratories.<sup>3</sup> Use of this nonspecific inhibitor may lead to inadequate results and often false positive reactions.

The demand for a more objective and less laborious assay that offers good sensitivity and specificity led us to evaluate the Rubazyme ELISA. The test employs an antibody-linked enzyme system for color change and determination of antibody level. It is quick and simple and requires no pretreatment of serum, no serial dilutions, and minimal amounts of antigens. We report in this paper the evaluation and comparison of HAI and Rubazyme methods using single serum from a large prenatal and premarital pool for determination of immune status to rubella virus.

## Materials and Methods

**Specimens.** Altogether, 1,039 single sera were tested from specimens submitted for routine prenatal and premarital screening for rubella virus at Oklahoma Memorial Hospital (OMH) serology laboratory.

**HAI.** The Ruba-test kit (Ortho Diagnostics, Raritan, NJ) was used to detect in a patient's serum antibody to rubella virus that will inhibit the virus or antigen's combination with and agglutination of the added RBC. If there were no antibody to rubella virus present in the patient's serum, the virus would agglutinate the RBC. The highest dilution of the patient's serum that completely inhibited agglutination of the RBC was the antibody titer of the serum. In our laboratory, a titer  $\geq 1:8$  indicated past rubella infection, at some undetermined time, and thus im-

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munity to primary infection. Details of HAI procedure and methodology has been described previously.<sup>4-6</sup>

**Rubazyme.** The Rubazyme kit (Abbott Laboratories, Diagnostic Division, Irving, Tex) was used in the ELISA studies. The instructions outlined by the manufacturer in the package inserts were precisely followed. A plastic bead coated with rubella virus was incubated with a diluted test specimen. An antibody complex with the rubella virus on the coated bead was formed if the serum was positive for rubella antibody. Unreacted serum components from the beads were washed and then incubated with antibody-enzyme conjugate (goat antihuman immunoglobulin plus enzyme horseradish peroxidase). The conjugate then reacted with the antibody antigen complex on the beads, resulting in a bead-antigen-antibody-enzyme complex. If, however, the serum specimen did not contain IgG antibody to rubella virus, the conjugate would not bind to rubella virus on the bead and would be removed by washing. An enzyme substrate was then added to determine the presence of enzyme on the bead surface, which was measured in a spectrophotometer adjusted to a wave length of 492 nanometers. A Rubazyme index of  $\geq 1.000$  indicates past infection with rubella virus and protection against primary infection. A reading lower than 1.000 indicates antibody to virus insufficient to provide protection against rubella infection. Standard high positive, low positive, and negative sera were included as control in the test.

**Data analysis.** Any disagreement in results was followed by a repeat run of each method. The results obtained a majority of the time by the two methods tested were considered to represent the accurate data.

## Results

A compilation of all positive, negative, and nonspecific agglutination results are shown in the table. A total of 1,039 serum specimens were tested in parallel with Rubazyme and HAI. The two procedures showed comparable results in 1,008 of the sera, giving a final agreement of 97%. Of the sera tested, 45 (3%) showed different results between the two procedures in both initial and repeat testing. Of these, 31 sera showed nonspecific agglutination by HAI despite pretreatment with heparin-MnCl to remove nonspecific inhibitors. By ELISA, 20 turned out to be negative (Rubazyme index avg 0.112) and the remaining 29 were positive. (Rubazyme index avg 2.050). As shown in the table, of the 152 specimens that were HAI negative (titer  $<1:8$ ), 5 were positive by ELISA (Rubazyme index avg 1.255). This Rubazyme index is weakly positive, indicating that ELISA is a more sensitive test than HAI. On the successive HAI serial dilutions of 1:8 and 1:16, 9

Comparison of Rubazyme Values with HAI on 1,039 Serum Specimens

HAI Titer	Number Sera Tested	Average Rubazyme Index	Discrepancy HAI Test w/Rubazyme
$<1:8$	152	$(0.040-1.272) = 0.656$	5 positive
1:8	16	$(0.676-1.735) = 1.205$	3 negative
1:16	182	$(0.625-2.922) = 1.773$	6 negative
1:32	264	$(1.002-2.959) = 1.980$	
1:64	217	$(1.031-3.312) = 2.171$	
1:128	98	$(1.373-3.956) = 2.664$	
$\geq 1:256$	79	$(2.064-4.258) = 3.161$	
Nonspecific agglutination	31	$(.104-2.988) = 1.551$	2 negative, 29 positive

more discrepancies were noted: 3 negative results (Rubazyme index avg 0.783) on 1:8 dilutions and 6 negative (Rubazyme index avg 0.855) on 1:16 dilutions. These discrepancies may have been due either to one or the other test giving false positive results or false negative results or to a minimal level of antibody to rubella. A third rubella antibody test procedure was not done to clarify these results.

## Discussion

A recent publication by Weissfeld et al<sup>7</sup> comparing several test systems for determining rubella immune status used HAI (Ruba-Tect, Abbott Laboratories), ELISA (Bio-Bead, Litton Bionetics), and indirect immunofluorescence (Fiax, International Diagnostic Technology). Their results suggested that commercial ELISA and indirect immunofluorescence are more sensitive than the commercial HAI. Moreover, ELISA can be performed without an expensive instrument for reading, which is not the case with indirect immunofluorescence.<sup>7</sup>

The results obtained from this comparative study showed a high degree of correlation between the ELISA and the HAI test for the detection of antibody to rubella virus. There are, however, several distinct advantages to the use of the ELISA method. From the procedural standpoint, Rubazyme is less time consuming and less difficult to perform. The methodology is simpler, with fewer steps. The color index is measured by a spectrophotometer, making readout very objective. On large-scale screening it can easily be automated. It also has an excellent predictive value of specificity as compared to the HAI test, more so because ELISA eliminates nonspecific agglutinins, which are often encountered in HAI.

Although the reagent and instrument cost of ELISA is about 20% more than HAI, when the savings in technologists' time in doing ELISA are taken into consideration, this method has a distinctive cost advantage over the HAI. □

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Syed M. H. Qadri, PhD, is a professor of pathology at the University of Oklahoma Health Sciences Center. A 1968 graduate of the University of Texas at Austin, he is a diplomate of the American Board of Medical Microbiology, a member of the American Society of Microbiology, and a Fellow of the American Academy of Microbiology.

Gertrude P. Chan, MD, is an assistant professor of microbiology at Manila's Santo Tamas medical school in the Philippines. She earned her medical degree at the University of Oklahoma in 1973 and specializes in mycology.

## Coming in January . . .

Among the manuscripts being prepared for publication in January are two papers on AIDS; one is from the Infectious Diseases Section of the University of Oklahoma's Department of Medicine and the other is from the Oklahoma State Department of Health. Also scheduled is an article on medicine in China, as observed by a group of US physicians

# HERO Is Here

Robert C. Hardy

*HERO: An Oral History of the Oklahoma Health Center* was released last month. Here the author of that book tells how it came to be.

While *HERO* tells how an academic, tertiary health care center grew from 3 to 11 institutions, from 8 to 35 buildings, from 3 to 7 colleges, from 920 to more than 3,200 students and from 24 acres to 200 acres in just 16 short years, it's really a story of and by the people who made it happen.

To the casual observer . . . and even to some of the medical staff, employees, and students who were there part of that time . . . it may have appeared to be a quiet and steady process of maturation.

It was anything but that!

To quote University of Oklahoma President Paul Sharp, "turmoil, stress, tension, misunderstandings, political rivalries, and 'confusion of tongues' accompanied it all."

Therein lies a fascinating tale, told by 155 people who created the Oklahoma Health Center — or tried desperately to keep it from happening. It is an intriguing, human story which reads more like fiction than history; one more proof that truth is indeed stranger. In fact, if it were fiction, you would be convinced the author suffered from hypertrophy of the imagination. Accounts of some of the events may seem totally contradictory because the people who relate this saga saw them from their own unique points of view.

The story starts in 1964, when James L. Dennis, a 1940 graduate of the OU College of Medicine, came back to his alma mater to become the dean and also director of the medical center. There are flashbacks

that tell about the problem-choked situation into which Dennis stepped. He dreamed of a greatly expanded health campus which would solve the problems of health service in Oklahoma by increasing the supply of doctors, nurses, and other health professionals to take care of people when they got sick.

For the first few years, the "pieces came together with amazing rapidity" and the "Oklahoma Plan" gained favor in Oklahoma and in Washington, DC. During subsequent years, however, the pieces periodically flew apart in the reality of Oklahoma politics and economics. The development of the Oklahoma Health Center took place over two decades during a fascinating period in the general history of medicine.

Most histories are presented from the single point of view of the writer. This story of the development of the Oklahoma Health Center is told through the eyes and experiences of 155 people who lived through it. After all, history is what people say it is, so the reader of *HERO* has the benefit of numerous delineations of "the truth," whatever that is.

*HERO* gives you behind-the-scenes insight into what went on, a close-up look at the Oklahoma Health Center, warts and all. As a pathologist once remarked about a patient, "The wonder is not what he died of but what he lived with." The wonder of the Oklahoma Health Center is how it achieved such remarkable growth despite the tugging and hauling, despite the power politics which characterized its development.

The physicians and decision-makers in the Oklahoma Health Center and every other academic, ter-

Robert C. Hardy, Oklahoma Health Sciences Foundation, 314 North Robinson, #A, Oklahoma City, OK 73102, (405) 271-4778.



tiary health care center in America face similar and equally difficult problems. Federal, state, university, and medical politics, to say nothing of the "town and gown" in academic health sciences communities, significantly affect the rate of progress. *HERO* provides a "reality check" for those in other centers, and for people outside the center, who may wonder if anybody has it quite as tough as they.

This oral history was pieced together over three years by Robert C. Hardy, executive of the Oklahoma Health Sciences Foundation, who not only observed the process for more than 18 of the 20 years the book covers but also traveled to both coasts and the Gulf to interview people who had a part in this project, spending uncounted hours listening to the players recount the exciting highlights of the high-stakes game of health campus development.

*HERO* is a massive volume: 430 pages with 402 photos, drawings, and charts. Despite the detail it includes, *HERO* is highly readable because it is laced with personal stories related by the movers who caused it all.

*HERO* is more than a 20-year "yearbook." Of course, it covers chronology, relates the facts, and pictures the people, but more importantly, it explores the motivations of the players . . . why they did what they did and how they felt about it all. *HERO* is more than the story of a campus full of buildings. It probes the issues of health services, burgeoning biotechnology, and shrinking federal support for health sciences education. And it demonstrates how solutions to some of these issues are obscured, even obstructed by the contrary ideas and ambitions of people who are really part of the problem.

*HERO* is essential reading for those who want to understand the problems of health sciences education and medical services development in the immediate past and the changes which will likely come about in the immediate future.

The story of the Oklahoma Health Center is told by:

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Senator Bryce Baggett  
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Wayne Beal  
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## Early-Day Physician

**Lloyd Thomas Lancaster, MD**  
**Born 1878 in Bridgeport, West Virginia**  
**Graduated from Baltimore School of Medicine,**  
**29 North Bond Street, 1904**  
**Interned at Baltimore University, 1904-1905**  
**Came to Avar, Oklahoma, to practice in 1905**

**D**r Lancaster practiced in Avar until 1909. He then moved to Cherokee, Oklahoma where he practiced until his death in 1948. His premature death was caused by a malignancy of his hands from X-ray exposure.

This author was examined by him in 1942. I, along with many friends enlisted in the Army one year to the day after Pearl Harbor, December 7, 1942, in Cherokee, Oklahoma. His fee was \$2.00 which he waived as I did not have the \$2.00 to pay and since

I was voluntarily enlisting. I can still remember his kindness and concern.

The present Physician has much to learn from our predecessors such as Dr Lancaster. His daughter is in the Beaver County Nursing Home under my care and is the informant of this article. He also delivered my wife and was her family Physician.

The accompanying picture shows him in Avar in his Orient Automobile which was purchased from Waltham Manufacturing Company, known as Orient Waltham. The automobile was purchased for \$150.00. It had been in storage long enough that the batteries (Dry Cell) had deteriorated. This was a two cylinder, eight horse power car.

*Submitted by*  
*E. L. Calhoon, MD*  
*Beaver, Oklahoma*

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## News from the Oklahoma State Department of Health

### Infectious Diseases in Day Care

As a result of the increase in the number of working women and single-parent families in the US in the last two decades, the number of children attending child-care settings has increased dramatically. Some studies have estimated that over 10 million children in the US receive some form of child care on a regular basis. In Oklahoma, 45,000 to 50,000 children attend licensed day care. It is possible that an equal number of children attend unlicensed facilities. Day-care facilities (day-care centers, nurseries, day-care homes) present a unique epidemiologic environment for the transmission of a variety of diseases. Day-care-center transmission of several infectious diseases occurs, including hepatitis A; meningococcal disease; *Haemophilus influenzae* invasive infections; measles; respiratory illnesses such as influenza, respiratory syncytial virus, adenovirus, and mycoplasma; and for bacterial (*Shigella*), viral (Rotavirus), and parasitic (*Giardia*, *Cryptosporidium*) enteric diseases.

Transmission of most diseases is probably related to the ages and behavior of the children enrolled, the degree of crowding, and the hygiene levels of those giving the child care. Other factors, such as hours of operation and the acceptance of "drop-in" children, have been shown to be important in the introduction and spread of hepatitis A in day-care centers. In general, younger children, particu-

larly infants and toddlers, are most susceptible to diseases of concern in this environment. Young children are also often the best transmitters of infectious diseases because of their need for close personal contact and supervision, fecal incontinence, frequent oral contact with objects in their environment, and the hygiene problems associated with these behavioral characteristics. Infected children may spread their diseases not only to other children and staff in the day-care setting but also to their households and extended families and ultimately to the community at large.

Steps in the prevention and control of infectious diseases in day care including the following:

- Recognition and reporting of communicable diseases, especially those related to the day-care setting. This requires eliciting a history of day-care exposure in a person who has a communicable disease; for a child, this means asking about attendance at day care, and for an adult, asking about household contacts who attend day care. Prompt reporting of such instances to the local health department will allow timely intervention to prevent spread of the disease.

- Exclusion from day care of persons who are in the communicable phase of a disease, including children who have fever, diarrhea, or rash illness.

- Education of day-care staff about the importance of good hygiene, especially strict handwashing after diaper changing; this also includes supervision of handwashing among older children before eating and after bowel movements.

Successful control of day-care-related diseases depends upon coordination and cooperation between the practicing physician, whose work is essential in recognizing, diagnosing, and promptly reporting the disease, and public health personnel, whose prompt response is necessary to interrupt further spread. □

DISEASE	September 1985	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	2	12	6	17
CAMPYLOBACTER INFECTIONS	22	245	145	—
ENCEPHALITIS, INFECTIOUS	2	25	20	23
GIARDIA INFECTIONS	53	238	207	—
GONORRHEA (Use ODH Form 228)	1,284	9,699	9,666	11,484
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	15	159	143	—
HEPATITIS A	37	361	352	377
HEPATITIS B	15	157	135	190
HEPATITIS, NON-A NON-B	5	50	39	—
HEPATITIS UNSPECIFIED	5	65	83	154
MEASLES (RUBEOLA)	0	1	8	163
MENINGITIS, ASEPTIC	10	95	82	137
MENINGITIS, BACTERIAL				
(non-meningococcal, non H. Influenzae)	3	55	35	43
MENINGOCOCCAL INFECTIONS	1	23	23	25
PERTUSSIS	15	158	237	106
RABIES (Animal)	7	88	90	148
ROCKY MOUNTAIN SPOTTED FEVER	9	80	113	113
RUBELLA	0	1	0	1
SALMONELLA INFECTIONS	63	312	302	343
SHIGELLA INFECTIONS	99	225	163	249
SYPHILIS (Use ODH Form 228)	22	156	144	139
TETANUS	0	0	2	0
TUBERCULOSIS	17	189	159	229
TULAREMIA	1	14	17	23
TYPHOID FEVER	2	2	3	3

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	11
BRUCELLOSIS	4
LEGIONNAIRES DISEASE	10
MALARIA	3
REYE SYNDROME	2
TOXIC SHOCK SYNDROME	11
<b>RABIES</b>	
BECKHAM	Cow 1
CANADIAN	Skunk 1
HARMON	Skunk 1
KIOWA	Cow 1
OTTAWA	Skunk 1
ROGERS	Bat 1
TULSA	Bat 1

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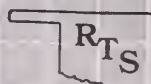
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*Whittington, Smith, Horowitz, et al*

## State doctors "get involved," get elected to key offices

Oklahoma physicians are continuing their winning ways in their national professional organizations, bringing honor and recognition to themselves and their communities and state.

**Kenneth Whittington, MD**, Bethany, has been elected to a three-year term on the Board of Directors of the American Academy of Family Physicians (AAFP). He was elected during the annual meeting of the AAFP's Congress of Delegates in Anaheim, Calif, in October. The congress — the academy's governing body — consists of two representatives from each of the 54 constituent chapters.

Dr Whittington has represented Oklahoma in the past as a delegate and alternate delegate to the AAFP congress. A 1968 graduate of the University of Oklahoma College of Medicine, he is in private practice in Bethany and is chief of staff at Bethany General Hospital.

An active member of the AAFP, Whittington has been a member and chairman of its Chapter Affairs Committee. He chaired the Reference Committee on Reports of Officers and Committees at last year's congress. On the state level, he has served as president of the Oklahoma Academy of Family Physicians.

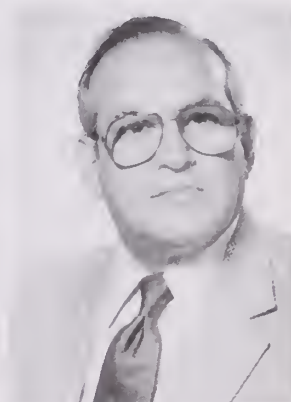
Whittington is a diplomate of the American Board of Family Practice and a charter AAFP Fellow. The AAFP is the national association of family physicians, representing some 55,000 family physicians and medical students.

**William R. Smith, MD**, Enid, a practicing internist, was elected to a second three-year term as a member of the Board of Trustees of the American Society of Internal Medicine (ASIM) at the society's 29th annual meeting in October in Washington, DC.

An ASIM trustee since 1982, Dr Smith is a past president of the ASIM/Socio-Economic Research and Education Foundation (SEREF) and continues on SEREF's Board of Trustees. He currently chairs the ASIM Long-Range Planning Committee and is a member of the Continuing Physician Education Advisory Committee, Board Nominating Committee, and Meetings Committee. A past president of the Oklahoma Society of Internal Medicine, Dr Smith is a trustee of the Oklahoma Medical Research Foundation, past president of the Garfield County Medical Society, and a Fellow of the American College of Physicians (ACP).

Dr Smith earned his medical degree from the Uni-

Among OSMA's "involved" physicians are (left to right) Kenneth Whittington, MD, Bethany; William R. Smith, MD, Enid; and Leon Horowitz, MD, Tulsa.







**Claude E. Lively, MD,** (left) receives from OSMA President **Elvin M. Amen, MD,** a special plaque commemorating his fifty years as a practicing physician. A standing ovation follows (right). The presentation was made at the monthly meeting of the Pittsburg County Medical Society in October. Dr Lively, a resident of McAlester and a Life Member of the OSMA, earned his medical degree at the University of Oklahoma in 1934.

## State doctors "get involved" (continued)

versity of Oklahoma and is certified by the American Board of Internal Medicine. He maintains a private practice in Enid and is associate clinical professor of medicine at the University of Oklahoma.

**Leon Horowitz, MD,** of the Allergy Clinic of Tulsa, Inc., has been nominated for the office of vice-president of the American Academy of Allergy and Immunology. The election will take place at the academy's annual meeting in New Orleans in March 1986.

Dr Horowitz has been a pediatrician and allergist in Tulsa since 1955. He formed the Allergy Clinic of Tulsa, Inc., in 1971 and serves as its president. Horowitz is trained and board certified in pediatrics and pediatric allergy and is a Fellow of the American Academy of Pediatrics, the American College of Allergy, and the American Academy of Allergy and Immunology. A past president of the Oklahoma Allergy Society, he is a clinical professor of pediatrics at the University of Oklahoma Tulsa Medical College.

In past years he has served on the academy's Penicillin Allergy Committee, the Insect Sting Allergy Committee, and the Public Relations Committee. The academy membership includes 3,500 practicing physicians, academicians, and research scientists from the United States, Canada, and 41 other countries.

**J. D. McKean, Jr., MD,** Oklahoma City, is the new vice-president of the American College of Emergency Physicians (ACEP). He was selected at the 1985 ACEP Board of Directors meeting during

the ACEP Scientific Assembly in Las Vegas in September.

As vice-president of the 11,200-member organization, Dr McKean will coordinate orientation programs for new board members, conduct liaison activities with other organizations, and chair meetings in the absence of the president.

Dr McKean is an emergency physician at Oklahoma City's Presbyterian Hospital and at Midwest City Memorial Hospital. He is also director and president of Emergency Physicians of Oklahoma, Inc. He is a 1967 graduate of the University of Oklahoma College of Medicine.

**Morris J. Wizenburg, MD,** Oklahoma City, was elected secretary of the American Society for Therapeutic Radiology and Oncology at the society's annual meeting in Miami Beach, Fla, earlier this fall. The society, headquartered in Reston, Va, is the largest organization in the world dedicated to improving cancer care through the science of radiation oncology.

These honors come in the wake of others reported in the JOURNAL earlier this year. In March, C. S. Lewis, Jr., MD, Tulsa cardiologist, was named president-elect of the American College of Physicians (ACP). In May, Alexander Poston, MD, Oklahoma City, was elected to the Board of Directors of the American Academy of Medical Directors, and in June, Perry A. Lambird, MD, Oklahoma City, won a seat on the AMA's Council on Member Service. □

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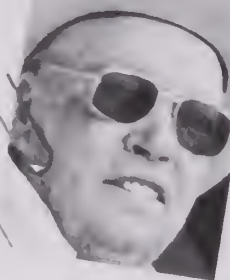
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## AMA offers new strategies as AIDS grabs more headlines

With documented evidence that the AIDS virus now is spreading to heterosexuals, researchers are offering new strategies to contain the infectious agent that destroys the body's immune system. The suggestions are based on new studies reported in the *Journal of the American Medical Association (JAMA)* that confirm the spread of AIDS both to heterosexuals and to three hospital workers, one of whom apparently infected her sexual partner even though she did not show presence of AIDS antibodies.

In an editorial comment, Dean F. Echenberg, MD, PhD, recommends tracing all heterosexuals thought to have been exposed to the AIDS retrovirus. This is possible, he asserts, because the prevalence of infection among heterosexuals still is less than 1%. "We know that AIDS is spreading within the heterosexual population. The only question is how fast and how widely," he says.

**Echenberg doubts that a mass education campaign will curb the spread of AIDS** among heterosexuals, despite the effectiveness of such campaigns among homosexual men in San Francisco. "The immediacy of AIDS that has driven changing sexual practices in the San Francisco gay community is lacking" in the much larger and more diverse heterosexual population, he notes.

Between 40% and 60% of the homosexual men in San Francisco are now infected with the AIDS virus. Since the virus already has appeared in the heterosexual population, the AIDS epidemic clearly will not be limited to high-risk groups, Echenberg warns. The problem of containing the virus is linked to its long incubation time. "Since AIDS has an incubation period of up to five years, asymptomatic infected heterosexuals may be unknowingly spreading (the virus) to their sexual contacts," he says. Hence the need for rigorous tracking of individuals possibly exposed to the virus. Infection with the virus is determined by the presence of antibody to the virus in a person's blood.

**Echenberg's comments accompany a new study from the Walter Reed Army Institute of Research in Washington, DC.** Robert R. Redfield, MD, and colleagues recently evaluated 41 patients with AIDS and found that 15 of these patients (37%) acquired the infection from a sexual partner(s) of the opposite sex. "Heterosexual contact with partners who developed AIDS or who were at risk for AIDS was confirmed in 6 patients," they report. "The remaining 9 patients had multiple (more than 50) heterosexual partners and/or sexual contact with

prostitutes." The researchers add that the type of sexual activity did not appear to be related to disease acquisition, but that receptive anal intercourse was definitely not implicated.

"The epidemiology of HTLV-III disease resembles that of hepatitis B virus, an agent clearly heterosexually transmissible," Redfield and colleagues say. They add that it is not clear how the virus is transmitted from women to men; the virus has been isolated from semen and saliva, but has not yet been reported to be found in vaginal secretions.

**Another major study describes three cases of AIDS virus infection in hospital workers** who accidentally punctured their hands with needles used on patients with AIDS. Stanley H. Weiss, MD, of the National Cancer Institute, and colleagues report that although one of these workers did not show presence of antibody, she apparently transmitted the virus to her sexual partner. The other two workers (and one worker's sexual partner) are antibody-positive. Of 39 total workers who reported possible exposure through such injuries, no other cases of infection were noted.

"The risk of nosocomial HTLV-III transmission appears to be low and related to percutaneous exposure," the researchers conclude. They add that systematic training in the handling of phlebotomy instruments should reduce the risk of occupational exposure.

**Difficulties remain in collecting and interpreting data** from persons thought to be at risk for AIDS. Commenting on the Weiss study, Lawrence D. Grouse, MD, PhD, observes, "It is impossible for a study to come to valid conclusions about transmission



The OSMA Auxiliary held its October Long Range Planning meeting in the board room at OSMA headquarters in Oklahoma City. Here Kelsey Walters, president-elect; Pam Oster, past president; and Julie Weedn, first vice-president, go over the agenda.

## Planned Parenthood book looks at methods, laws, and ethics

The Planned Parenthood Federation of America (PPFA) has announced publication of *Frontiers in Fertility*, a comprehensive description of the technologies that are transforming reproductive health care. The 68-page book is based on medical, legal, and ethical papers presented at the PPFA's Symposium on Human Fertility Regulation last December.

### AMA offers strategies (continued)

of HTLV-III infection without complete knowledge of patient risk factors. It is unlikely that such documentation would be possible without the guarantee of complete confidentiality that was provided in this study."

In the Letters section, Michael Marmor, PhD, of New York University Medical Center, and colleagues stress the need for better educational efforts for drug abusers. They note that more than 50% of this high-risk group in New York City may be infected with the virus. They also point out that many prostitutes are IV drug users, which increases their chances of infectivity.

In another letter, Neil Schram, MD, past president of the American Association of Physicians for Human Rights, San Francisco, says physicians should inform their patients that everyone who is not in a mutually monogamous relationship is at some risk of acquiring AIDS, but adds that it is unreasonable to expect celibacy for those who are infected or monogamy for those not infected. Schram also calls for more study of the possible transmission of the virus through kissing. □

*Frontiers in Fertility* provides the latest information on technologies ranging from "test-tube" fertilization and embryo transfer, to prenatal testing and therapy, to treatment of seriously ill, premature newborns.

Faye Wattleton, PPFA president, says the book "presents the technology and the related issues in language designed to make the information accessible to both family planning professionals and others who may be unfamiliar with the subject."

She adds, "Researchers have made astounding progress in developing new reproductive technologies. *Frontiers in Fertility* explains the technologies themselves and outlines the many complex issues that Planned Parenthood and other concerned organizations must address."

*Frontiers in Fertility* covers new technologies in three areas:

- "Alternatives in Conception" covers new ways to conceive a child or to select its gender or other characteristics.

- "Prenatal Responsibilities" explores implications of more widely available prenatal testing and therapies that treat the fetus while it is still in the uterus. This section also covers maternal substance abuse, forced cesarean section, and prenatal responsibility and education.

- "Late Abortion/Seriously Ill Neonates" discusses whether the concept of fetal viability (the ability of the fetus to live outside the womb, albeit with artificial aid) should continue to guide abortion law.

*Frontiers in Fertility* is available from PPFA, 810 Seventh Avenue, New York, NY 10019, for \$8.95 plus \$1.50 postage. □



**James B. Eskridge III, MD**, OSMA past president and chairman of the Council on Long Range Planning and Development, leads the discussion at the council's October meeting. Among those attending the meeting, shown here, are Arnold G. Nelson, MD, Midwest City; M. Joe Crosthwait, MD, Midwest City; OSMA Legal Counsel Ed Kelsay, Oklahoma City; OSMA President Elvin M. Amen, MD, Bartlesville; OSMA Executive Director David Bickham, Oklahoma City; Orange M. Welborn, MD, Ada; and Michael J. Haugh, Tulsa. The meeting was held October 4 and 5 at the Fifth Season Inn in Oklahoma City.



Some individuals predisposed

## "Genes" not a lame excuse for alcoholics, study says

Alcoholism is a biologically influenced problem and not a symptom of moral weakness, according to a report in the *Journal of the American Medical Association (JAMA)*. Physicians who fail to change their stereotyped assessment of the alcoholic risk misdiagnosing the average middle-class alcoholic who needs help, the report adds.

Prepared by researcher Marc A. Schuckit, MD, of the University of California, San Diego, the report points out that children of alcoholics have a fourfold risk of becoming alcoholics themselves, even when adopted at birth. Furthermore, the likelihood of both twins of alcoholic parents becoming alcoholic themselves is 60% or higher when the twins are identical and only 30% or less when the twins are fraternal.

"The most impressive evidence supporting the importance of genetic factors in alcoholism comes from adoption-type studies," Schuckit says. "Once the influence of a biological alcoholic parent is considered, being reared by an alcoholic does not seem to add to the risk, and children of nonalcoholics raised by alcoholics do not appear to have an enhanced rate of this problem."

Based on his own studies of sons of alcoholics and matched controls, Schuckit postulates three marked differences between populations at high risk and at low risk of becoming alcoholic. "Sons of alcoholics appear to show less intense responses to modest ethanol doses, demonstrate lower amplitudes of a brain wave that might measure selective attention, and may have different characteristics of brain alpha rhythms."

Subjective and objective tests showed that sons of alcoholics were less affected by ethanol than were the controls. In addition, the controls showed poorer performance on a number of cognitive and psychomotor tests at the same ethanol dose. They also showed more intense changes in cortisol and prolactin, two hormones known to react to an acute ethanol challenge.

"There is consistent evidence that those in the high-risk group demonstrate significantly less intense reactions to modest doses of ethanol than those in the low-risk group," Schuckit reports. "It may be that they are feeling less ethanol effects at the blood alcohol concentrations at which most people make a decision to stop drinking."

(continued)

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## In vitro fertilization labs a joint effort in Tulsa and OKC

The Hillcrest Infertility Center of Tulsa has announced the development of a satellite in vitro fertilization (IVF) laboratory project at Baptist Medical Center (BMC) in Oklahoma City. The Hillcrest Infertility Center's co-directors J. Clark Bundren, MD, and J. W. Edward Wortham, Jr., PhD, anticipate that the embryo laboratory facilities will be completed in time to enable physicians at BMC to provide IVF procedures to their patients sometime in January 1986.

Oklahoma City infertility specialists involved in the project are David A. Kallenberger, MD; Royce B. Everett, MD; Tony G. Puckett, MD; Fenton M. Sanger, MD; and Michael R. Seikel, MD. Together they will staff the Henry G. Bennett, Jr., Fertility Institute at BMC. The Fertility Institute has contracted with the Tulsa-based Infertility Center to provide the complex laboratory systems necessary for successful in vitro fertilization. This is believed to be the first such arrangement for IVF in the US.

Part of the development will include the training of two IVF laboratory technicians. Training will require an intensive three-month program in Tulsa before moving to the laboratory in Oklahoma City, where all equipment and laboratory protocols developed by Dr Wortham will be identical to those at the Tulsa facility.

The Hillcrest Infertility Center has been in operation for almost three years. It is a joint effort of Hillcrest Medical Center and the University of Oklahoma Tulsa

Medical College. Drs Bundren and Wortham were recruited from Eastern Virginia Medical School, Norfolk, where they were directly involved in the 1981 laboratory conception and natural delivery of the first in vitro baby born in the US. Dr Wortham was director of the IVF laboratory there during that period.

The Hillcrest Infertility Center has been responsible for the births of 25 IVF babies. An additional 9 pregnancies are expected to continue to term. □

## Teen alcohol use a predictor of later drug use and abuse

Alcohol abuse in early adolescence is a strong predictor of later alcohol abuse and other drug problems, according to a report on substance abuse in the *Journal of the American Medical Association (JAMA)*. Robert L. DuPont, MD, of the Center for Behavioral Medicine, Rockville, Md, adds that the usual pathway to serious drug abuse begins with alcohol and/or cigarettes during the teen years and progresses to marijuana, then tranquilizers and other pharmaceuticals, cocaine, and for some, heroin.

"On the other hand, youths who do not use cigarettes and alcohol during their teenage years are virtually immune to the nonmedical use of other dependence-producing drugs," DuPont says, noting that the onset of nonmedical drug use is virtually limited to the teenage years, peaking between the ages of 15 and 18 years. He adds that physicians should educate patients and their families about substance abuse trends and should intervene when a problem is recognized.

DuPont's views reflect those of physicians in virtually every specialty and subspecialty, including pediatrics, geriatrics, family practice, cardiology, pulmonary medicine, occupational medicine, sports medicine, infectious diseases, and nutrition. Because most life-threatening illnesses are linked to personal choices, there is an increased emphasis on preventive medicine and on the role of the physician as advisor and educator. □

## "Genes" not lame excuse (continued)

Other studies, involving measurement of brain-stem auditory event-related potentials, show that sons of alcoholics have a lower value for a certain response, even without ethanol. "This might indicate that some of these young men may experience difficulties in adequately focusing attention on their surroundings." They also show a deficiency in the amount of alpha rhythm, or slow waves, in their background cortical EEGs, along with a possible greater increase of waves in the alpha band after drinking. This could indicate a qualitatively different type of "high" in the risk group.

No matter how genetic factors are expressed, they "can help us begin to work on preventing this illness," Schuckit says. "While the optimum approach to prevention has not been found, it makes sense that children of alcoholics should be educated about their risk, taught that they may not react to alcohol the way their peers do, and informed that attempting to drink like others could be a dangerous undertaking." □

**OSMA**  
**Physician Recovery Hotline**  
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*"There is a systematic bias . . ."*

## Congressman warns further cuts in Medicare may be skewed

Further cuts in Medicare outlays for elderly hospital patients threaten to be arbitrary spending reductions, warns Robert T. Matsui (D-Calif), US House of Representatives, in the *Journal of the American Medical Association (JAMA)*.

"Hospital costs increased only 4.5% in 1984, as compared with rates of 10.2% and 15.8% in 1983 and 1982, respectively," he says in an editorial in *JAMA*. "These statistics are dramatic and largely unanticipated. In fact, they are cause for us to examine carefully the implications of the vast changes in progress so as to avoid any deleterious effects on the quality and accessibility of hospital care," he adds.

The congressman's cautionary comments are aimed at the new prospective payment system (PPS) being phased in for hospital care of Medicare patients. Payments are based on the medical diagnosis of the patients and represent averages of treatment costs for various conditions. The system was to have a three-year implementation period, allowing time for further research on its effects and for refinements.

## AMA slates April meeting on impaired health professionals

The American Medical Association's Seventh National Conference on the Impaired Physician will be held April 11-13, 1986, at the Hilton Hotel and Towers in Chicago. The theme of the meeting is "Impairment and Well-Being of Health Professionals: A Family Affair."

The conference, which will focus not just on impaired physicians but also on allied health professionals, will serve as a forum for those involved with primary and/or secondary prevention and treatment of impairment. Attending will be hospital administrators, licensing board personnel, academic deans, residency training directors, spouses, and medical student leaders.

The AMA is sponsoring the meeting in cooperation with the American Dental Association, American Medical Veterinary Association, American Nurses' Association, American Pharmaceutical Association, American Podiatric Medical Association, American Medical Women's Association, and National Medical Association. The Illinois State Medical Society is acting as host.

Persons wishing further registration or program information should contact Janice Robertson at (312) 645-5079. □

"At the midpoint in our transition to a national pricing system, we find that much of the research agenda we set up has not been completed," Matsui says. "Studies are still in progress and virtually none of the expected refinements to the prospective payment system have yet been implemented. Complicating this situation is the fact that we are making further cuts in Medicare hospital outlays."

Among the serious problems is failure to distinguish differences in severity of illness of patients within the same diagnostic category, Matsui says. "Without a means of adjusting for these variations in costs within diagnosis-related groups (DRGs), there is a systematic bias against hospitals."

Other problems relate to regional variations in costs of labor and supplies and lack of adjustments for hospitals that treat large numbers of Medicare and low-income patients, he says. "What we are beginning to see with this imperfect system is large 'windfall' payments to hospitals in certain geographic areas and significant underpayments to similar hospitals in other areas," he adds.

Calling for an extension of the transition period, he says, "As we look to the future of the Medicare program, I believe that we have no higher obligation than to assure that present and future beneficiaries have access to high quality, economical health care."

"We must be prudent managers of the financial resources available for this program, but we must temper our fiscal restraint with the need to maintain a viable hospital system to serve all our citizens." □



At the October meeting of the OSMA Council on Long Range Planning and Development, M. Joe Crosthwait, MD, Midwest City, listens as Orange M. Welborn, Ada, offers a suggestion.



## The Ghost of Freedoms Past

As a first class citizen, I'd rate  
I've paid my taxes, pulled my weight.  
Kept my conscience free from sin  
Gone to church . . . least now and then.  
With little leagues, I've learned to play  
I've suffered hours of PTA.  
I've paid my bills, observed the laws  
And given to many a deserving cause.

But politics was not my dish,  
I'd rather golf, or hunt, or fish,  
When I was asked by Mr. Pate  
Would I support his candidate?  
I said I'd sent a prior check  
'Twas all a lie . . . but what the heck.  
When called to work for Senator White  
I said my schedule was too tight.

When precinct meetings rolled around  
I said that I was leaving town.  
When Party help was needed now  
I said, "They're all crooks, anyhow."  
Then when it came the time to vote  
I spent the day out in my boat,  
And life rolled on, day in day out  
About my future, I'd no doubt.

Then one night while dreaming fast  
I met the Ghost of Freedoms Past  
He led me from my snug, warm bed  
To show me things that lay ahead.  
He showed me faces, thin and bleak  
On folk who toiled through endless week,  
Meeting quotas, reaching goals  
Living under strict controls.

He showed me children reared by State  
Whose aim was to indoctrinate,  
Empty churches stood forlorn  
Worship outlawed, buildings torn.  
The Hall of Congress sealed by rust  
Ballot boxes collecting dust,  
He showed me life where fear was norm  
And all were clad in uniform.

He said when scientific tests were made  
My kids had been assigned a trade,  
Their lives a drudge, a menial chore  
They could aspire to nothing more.  
I'd been assigned . . . he then decreed  
To clinics where there was a need,  
I'd have a bed and board and clothes  
With coupons to exchange for those.

For such I'd file a six-part claim  
But sign my number, not my name,  
And serve each day without complaint  
The State had now become my Saint.  
I pleaded then, "It can't be true  
There must be something I can do."  
He sadly paused, and then he said  
"My friend, Democracy is dead.

There's just no way for legal fights  
The Courts are closed, and you've no rights.  
You had a chance in seventy-five  
To keep that marvelous thing alive.  
You simply said, 'The job's not mine.'  
Now this is nineteen-eighty-nine.  
For all the world, you didn't care  
While there were others waiting there.

To call your life style to a halt  
You lost your freedoms by default,  
You gave it up just inch by inch  
Those activists . . . they had a cinch.  
So here it is, no hope no joy  
Don't cry on me . . . you blew it, boy!"  
And just then, I awoke in sweat  
But I recall that nightmare yet.

Of life, with which I could not cope  
Devoid of dreams, devoid of hope,  
Devoid of warmth, devoid of love  
Devoid of guidance from above.  
I saw the error of my ways  
And I will spend my lasting days,  
Preserving all that we can be  
A nation proud and strong and free.

And like my forebears in the strife  
I'll pledge my honor, fortune, life.  
I'll hold my right to vote most dear  
And with it, keep your future clear.  
I'll work and give . . . support, oppose  
This land won't fall to some of those,  
Who want things I saw that night  
Who feel that socialism's right.  
This was my lesson. It will last.  
Learned from the Ghost of Freedoms Past.

— Rex Kenyon, MD

*Reprinted from the JOURNAL, April 1977. Rex E. Kenyon, MD, Oklahoma City pathologist, is a past president of the Oklahoma County Medical Society and of the Oklahoma State Medical Association. He has served on the AMA's Council on Legislation and, at the time he wrote this poem, was chairman of the AMPAC board of directors.*



## DEATHS

### John R. Cotteral, MD 1899 - 1985

OSMA Life Member John R. Cotteral, MD, of Henryetta died April 30, 1985. Dr Cotteral earned his medical degree at the University of Oklahoma School of Medicine in 1929 and went on to complete a general internship and residency in pediatrics in Oklahoma City hospitals. During World War II he was on active duty with the US Army for more than three years, achieving the rank of major.

### In MEMORIAM 1985

<i>Owen L. Hill, MD</i>	<i>January 15</i>
<i>Earl M. Lusk, MD</i>	<i>January 30</i>
<i>Larry L. Lowery, MD</i>	<i>February 12</i>
<i>Harry Wilkins, MD</i>	<i>February 14</i>
<i>William H. Buchan, MD</i>	<i>February 15</i>
<i>Austin H. Bell, MD</i>	<i>February 23</i>
<i>Glen W. McDonald, MD</i>	<i>February 25</i>
<i>E.C. Lindley, MD</i>	<i>March 1</i>
<i>Charles W. Freeman, MD</i>	<i>March 5</i>
<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>Forest R. Brown, MD</i>	<i>March 19</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Hanna B. Karam, MD</i>	<i>March 28</i>
<i>John R. Cotteral, MD</i>	<i>April 30</i>
<i>Ernest S. Kerekes, MD</i>	<i>June 8</i>
<i>L. Chester McHenry, MD</i>	<i>June 8</i>
<i>Seigul J. Polk, MD</i>	<i>June 10</i>
<i>Murray M. Cash, MD</i>	<i>June 11</i>
<i>Franklin Jesse Nelson, MD</i>	<i>June 13</i>
<i>Robert L. Kendall, MD</i>	<i>June 21</i>
<i>Marion K. Ledbetter, MD</i>	<i>July 3</i>
<i>James Floyd Moorman, MD</i>	<i>August 8</i>
<i>Oscar R. White, MD</i>	<i>August 14</i>
<i>Maurice P. Capehart, MD</i>	<i>August 29</i>
<i>Meredith M. Appleton, MD</i>	<i>September 7</i>
<i>Robert A. Northrup, MD</i>	<i>September 8</i>
<i>Carl H. Bailey, MD</i>	<i>September 9</i>
<i>Hugh B. Spencer, MD</i>	<i>September 13</i>
<i>Bernice E. McCain, MD</i>	<i>September 14</i>
<i>Robert Ray Rupp, MD</i>	<i>October 2</i>

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# Index to 1985 Contents

Items in this index are organized under the following headings: Authors, Auxiliary, Book Reviews, Commentary, Deaths, Editorials, Index to Advertisers, In Memoriam, Instructions for Authors, The Last Word, Miscellaneous Advertisements, News, News from the Oklahoma State Department of Health, Pictures, President's Page, Reaction Time, Scientific, and Special Articles. In author entries, titles of articles appear only with the lead author; entries for coauthors refer to the lead author.

## Pages included in each issue

January .....	1-30	July .....	209-298
February .....	31-60	August .....	299-336
March .....	61-96	September .....	337-362
April .....	97-132	October .....	363-406
May .....	133-166	November .....	407-438
June .....	167-208	December .....	439-467

## Key to abbreviations

(B) Book Review	(L) Letter
(C) Commentary	(S) Scientific
(E) Editorial	(Sp) Special
(H) State Health Dept	

## Authors

Amen EM: The Hippocratic oath (E) .....	168
Amen EM: The president's page (E) .....	134, 168, 210 300, 338, 364, 408, 440
Asal NR: See Omondi PPG .....	304
Bahr CB: <i>Diabetes Mellitus and Obesity</i> (B) .....	164
Blumenthal H: See Wortham EV .....	99
Berry HK III: Attorney invites editor to move to Russia (L) .....	123
Boren DL: Senator replies to Amen letter (L) .....	332
Bowman RC: "Sad Consensus" editorial still provoking reactions from MDs (L) .....	358
Brandt EN Jr: The future of graduate medical education (C) .....	340
Calhoon EL: Early-day physician (Sp) .....	453
Carpenter NJ: See Wilson DP .....	37
Carter MD: See Chooi LMF .....	301
Chambers SL: Physicians abroad: The wise women of Clamart (Sp) .....	106
Chan GP: See Qadri SMH .....	448
Chooi LMF, Fine DP, Muchmore HG, Carter MD, Wilson DA, Tisdal RG: Bilaterally enlarged adrenal glands — an important clue to disseminated histoplasmosis (S) .....	301
Coleman WO: Delegate reports AMA action on manpower problems (L) .....	332
Coussons HW: <i>Native American Art at Philbrook</i> (B) .....	93
de la Rocha SR: Home care: A better alternative for the ventilator-dependent child (S) .....	409
DePersio, SR: see Fermo AV .....	169
Duffy FD, Lewis CS Jr, Miller DA: Estimated physician manpower requirements for Oklahoma in 1990 (Sp) .....	183
Eaton BG: <i>Radiology of the Colon: Golden's Diagnostic Radiology</i> (B) .....	360
Endres RK: See Wilson DP .....	3
Endres RK: See Wilson DP .....	211
Eskridge JB III: Anatomy of a successful resolution (E) .....	2
Eskridge JB III: Monkey see, monkey do... (E) .....	32
Eskridge JB III: Something special... (E) .....	62
Eskridge JB III: Who listens??... (E) .....	98
Fermo AV, DePersio SR, Lorenz D, Oberle M: Recent trends in pregnancy among teenagers in Oklahoma (S) .....	169
Fine DP: See Chooi LMF .....	301
Flournoy DJ: See Omondi PPG .....	304
Flournoy DJ: See Thompson JE .....	444
Flournoy DJ: See Winter WK .....	12
Forrest JB: Observations on the hormonal response of metastatic prostatic carcinoma (S) .....	104
Gajda JF: An analysis of petitions for court commitment to psychiatric care filed in Tulsa County (Sp) .....	420
Green R: Leaders in medicine: William C. McCurdy, Jr., MD (Sp) .....	65
Green R: Leaders in medicine: W. W. Rucks, Jr., MD (Sp) .....	365
Greenwood RD "Child crowing" (croup, 1836-1889) (Sp) .....	143
Groom D: Retired OKC physician disputes MRJ's "gloom and doom"... (L) .....	160
Haines JD Jr: Prison riot! (Sp) .....	108
Hall WH: Doctor calls for reevaluation of lipid in TPN (L) .....	228
Hardy RC: HERO is here (Sp) .....	451
Harolds JA: See Streight RA .....	8
Hawk JC Jr: South Carolina doctor envies our status as unified state (L) .....	358
Hinson BR: Editor's hammering on the mark (L) ..	161



## Authors (continued)

Holcombe JH: See Wilson DP	37	disaster (C)	313
Holmes JE, Miller DA: A study of 138 return service scholarship applications (S)	384	Postier RG, O'Malley V, Welsh JD: Continence-preserving operations in the management of ulcerative colitis (S)	33
Holt RJ: Eliminating pharmacists' calls (Sp)	215	Price LD: See Walls LL	72
Horowitz L: Tulsa doctor offers security tip (L)	332	Prothro GW: See Walls LL	72
Hrdlicka LJ: "Now now reflex" observed in Claremore, says case report (L)	437	Qadri SMH, Chan GP: Comparison of Rubazyme with haemagglutination inhibition test for determination of antibody to rubella virus (S)	448
Johnson MR: Not for Christmas only (E)	439	Ramirez ME: Cooperation and congratulation echo from AMA meeting (L)	358
Johnson MR: A divine suggestion (E)	31	Rayan GM: Orthopedic management of rheumatoid disease of the upper limb	78
Johnson MR: Anyone else need help? (E)	209	Rich C: Production and utilization of physicians in Oklahoma (C)	217
Johnson MR: Great way to go (E)	61	Riddle JD: Botulism — A case report (S)	441
Johnson MR: Heading into the sunset (E)	167	Riley HD Jr: <i>Allergic Diseases of Infancy, Childhood and Adolescence</i> (B)	335
Johnson MR: Let's give ourselves this year (E)	363	Riley HD Jr: <i>Cerebrospinal Fluids in Diseases of the Nervous System</i> (B)	13A (Jun)
Johnson MR: Medical care triumphs (E)	97	Riley HD Jr: <i>Clinical Pediatric Dermatology</i> (B)	334
Johnson MR: No matter (E)	1	Riley HD Jr: <i>Communicable and Infectious Diseases</i> (B)	438
Johnson MR: Now now: The premorbid reflex (E)	337	Riley HD Jr: <i>Contemporary Standards for Antimicrobial Usage</i> (B)	360
Johnson MR: Phony drugs and foolish decisions (E)	299	Riley HD Jr: <i>Coping with the Biomedical Literature: A Primer for the Scientist and the Clinician</i> (B)	93
Johnson MR: Some ironies about housecleaning (E)	407	Riley HD Jr: <i>Dermatology for the House Officer</i> (B)	232
Johnson MR: Too bad to be true (E)	133	Riley HD Jr: <i>The Freezing of Mammalian Embryos</i> (B)	405
Kerr T: Special Olympics director says thanks to OSMA (L)	333	Riley HD Jr: <i>Grant's Method of Anatomy by Regions Descriptive and Deductive</i> (B)	334
Krenning LE: See Walls LL	72	Riley HD Jr: <i>Hepatrophic Factors</i> (B)	360
Lewis CS Jr: See Duffy FD	183	Riley HD Jr: <i>The Human Herpesviruses: An Interdisciplinary Perspective</i> (B)	404
Long HL: See Mohr JA	380	Riley HD Jr: <i>Infections in the Abnormal Host</i> (B)	333
Lorenz D: See Fermo AV	169	Riley HD Jr: <i>Iron Metabolism</i> (B)	360
Mackie L: <i>Core Studies in Obstetrics and Gynecology</i> (B)	165	Riley HD Jr: <i>Laboratory Medicine: Hematology</i> (B)	405
Mallonee J: See Odunze EE	139	Riley HD Jr: <i>The Maya Book of the Dead: The Ceramic Codex. The Corpus of Codex Style Ceramics of the Late Classic Period</i> (B)	230
McCall CB: Former dean sends letter of appreciation to OSMA friends (L)	359	Riley HD Jr: <i>Pediatric Cardiology</i> (B)	230
McCoy PB: <i>Oxygen Free Radicals and Tissue Damage</i> (B)	163	Riley HD Jr: <i>Pediatric Procedures</i> (B)	335
McCurdy WC III: Satellite call links McCurdys (L)	161	Riley HD Jr: <i>Pediatric Surgery</i> (B)	334
Miller DA: See Duffy FD	183	Riley HD Jr: <i>Peptide Transport and Hydrolysis</i> (B)	360
Miller DA: See Holmes JE	384	Riley HD Jr: <i>Retrolental Fibroplasia: A Modern Parable</i> (B)	336
Mohr JA, Long HL: A chronic illness and geriatric assessment, evaluation, and rehabilitation unit (S)	380	Riley HD Jr: <i>Rickettsiae and Rickettsial Diseases</i> (B)	404
Morrison RD: See Tsegaye A	375	Riley HD Jr: <i>Surface Anatomy. An Instruction Manual</i> (B)	335
Morrison RD: See Tsegaye A	414	Riley HD Jr: <i>Surgical Infections: Selective Antibiotic Therapy</i> (B)	124
Muchmore HG: See Chooi LMF	301	Riley HD Jr: <i>Survivors, Victims, and Perpetrators: Essays on the Nazi Holocaust</i> (B)	405
Muchmore HG: See Omondi PPG	304	Riley HD Jr: <i>Surgical Infectious Diseases</i> (B)	230
Newell SW, Walser JJ: Nursing home glaucoma and visual acuity screening results in Garfield County (S)	16	Riley HD Jr: <i>Textbook of Pediatric Infectious Diseases</i> (B)	404
Newmark SR: Nutrition for the practitioner VI: Current concepts in nutrition: Vitamin K (S)	46	Riley HD Jr: <i>Theories of Fever from Antiquity to the Enlightenment</i> (B)	438
Oberle M: See Fermo AV	169	Ritchey CR: See Tsegaye A	375
Odunze EE, Silberg SL, Mallonee J: Epidemiologic study of prostate cancer in Oklahoma: six-year review, 1975-1980 (Sp)	139	Ritchey CR: See Tsegaye A	414
O'Malley V: See Postier RG	33	Robinson MG: Coming attractions (SA)	19
Omondi PPG, Asal NR, Muchmore HG, Flournoy DJ: Epidemiology of nontuberculous mycobacteria in Oklahoma (S)	304		
OSMA Council on Medical Education: Physician manpower production critique, state of Oklahoma (Sp)	191		
Pitts RJ: See Walls LL	72		
Poarch JE: Nightmare afternoon: The Star School			

Rosenkoetter G: See Wilson DP .....	3
Rowsey JJ: Lawsuit illustrates quandary (L) .....	123
Segler S: See Young JA .....	343
Silberg SL: See Odunze EE .....	139
Silverstein S: A student's view: A changing attitude in changing times (E) .....	339
Stone HL: <i>Perspectives in Biomechanics</i> (B) .....	124
Streight RA, Harolds JA: Intraoperative ultrasound (S) .....	8
Tompkins RG: <i>A Pocket Manual of Differential Diag- noses</i> (B) .....	163
Thompson JB: I'd do it again, Tulsan assures MRJ (L) .....	29
Thompson JE, Flournoy DJ: Airborne bacterial con- tamination from patients on MA-1 volume ven- tilators (S) .....	444
Thrift N: Keeping in touch: Notes from the OFPR (Sp) .....	146
Tinker RA: Results of a nutrition information study among family practitioners in Oklahoma County (S) .....	43
Tisdal RG: See Chooi LMF .....	301
Tsegaye A, Ritchey CR, Morrison RD: Hypertension I: The relationship of hypertension to serum cholesterol, triglycerides, and sodium (S) .....	375
Tsegaye A, Ritchey CR, Morrison RD: Hypertension II: Statistical correlation of seventy-eight diet com- ponents to blood pressure (S) .....	414
Vorse HB: <i>Medical Office Design: Territory and Con- flict</i> (B) .....	359
Walls LL, Prothro GW, Krenning LE, Pitts RJ, Price LD: The role of the teaching nursing home in res- idency education (S) .....	72
Walser JJ: See Newell SW .....	16
Welsh JD: See Postell RG .....	33
Westbrook BR: Reader disputes MRJ's "consensus" (L) .....	59
Westerman EL: Limiting antibiotics on the hospital formulary (S) .....	176
Whang R: See Wood CL .....	135
Whitsett TL: <i>New Perspectives on Calcium An- tagonists</i> (B) .....	359
Wilson DA: See Chooi LMF .....	301
Wilson DP, Carpenter NJ, Holcombe JH: Turner syn- drome: Clinical investigations and review (S) ...	37
Wilson DP, Endres RK: Continuous subcutaneous in- sulin infusion (CSII) (S) .....	211
Wilson DP, Rosenkoetter G, Endres RK: Self-monitor- ing of blood glucose (S) .....	3
Winter WK, Flournoy DJ: To shave or not to shave intravenous sites (S) .....	12
Wood CL, Whang R: Oral anticoagulant-induced femoral nerve entrapment (S) .....	135
Wortham EV, Blumenthal H: Diplopia: A Review of 48 cases of isolated ocular cranial neuropathy (S) .	99
Young JA, Segler S: Outpatient cisplatin chemo- therapy in a community hospital cancer center (S) .....	343

## Auxiliary

Auxiliary page .....	29A (Jan), 33A (Feb) 39A (Mar), 43A (Apr), 35A (May), 31A (Sep), 33A (Oct), 35A (Nov), 27A (Dec)
----------------------	--

## Book Reviews

<i>Allergic Diseases of Infancy, Childhood and Adoles- cence</i> (Riley HD Jr) .....	335
<i>Atlas of Mammography: Histologic &amp; Mammo- graphic Correlations</i> (Haberman JD) .....	94
<i>Cerebrospinal Fluids in Diseases of the Nervous Sys- tem</i> (Riley HD Jr) .....	13A (Jun)
<i>Clinical Pediatric Dermatology</i> (Riley HD Jr) .....	334
<i>Communicable and Infectious Diseases</i> (Riley HD Jr.) .....	438
<i>Contemporary Standards for Antimicrobial Usage</i> (Riley HD Jr) .....	360
<i>Coping with the Biomedical Literature: A Primer for the Scientist and the Clinician</i> (Riley HD Jr) ...	93
<i>Core Studies in Obstetrics and Gynecology</i> (Mackie) .	165
<i>Dermatology for the House Officer</i> (Riley HD Jr) ...	232
<i>Diabetes Mellitus and Obesity</i> (Bahr CB) .....	164
<i>The Freezing of Mammalian Embryos</i> (Riley HD Jr) .	405
<i>Grant's Method of Anatomy by Regions Descriptive and Deductive</i> (Riley HD Jr) .....	334
<i>Hepatotropic Factors</i> (Riley HD Jr) .....	360
<i>The Human Herpesviruses: An Interdisciplinary Per- spective</i> (Riley HD Jr) .....	404
<i>Infections in the Abnormal Host</i> (Riley HD Jr) ...	333
<i>Iron Metabolism</i> (Riley HD Jr) .....	360
<i>Laboratory Medicine: Hematology</i> (Riley HD Jr) ...	405
<i>The Maya Book of the Dead: The Ceramic Codex. The Corpus of Codex Style Ceramics of the Late Classic Period</i> (Riley HD Jr) .....	230
<i>Medical Office Design: Territory and Conflict</i> (Vorse HB) .....	359
<i>Native American Art at Philbrook</i> (Coussons HW) .	93
<i>New Perspectives on Calcium Antagonists</i> (Whitsett TL) .....	359
<i>Oxygen Free Radicals and Tissue Damage</i> (McCoy PB) .....	163
<i>Pediatric Cardiology</i> (Riley HD Jr) .....	230
<i>Pediatric Procedures</i> (Riley HD Jr) .....	335
<i>Pediatric Surgery</i> (Riley HD Jr) .....	334
<i>Peptide Transport and Hydrolysis</i> (Riley HD Jr) ...	360
<i>Perspectives in Biomechanics</i> (Stone HL) .....	124
<i>A Pocket Manual of Differential Diagnoses</i> (Tompkins RG) .....	163
<i>Radiology of the Colon: Golden's Diagnostic Radio- logy</i> (Eaton BG) .....	360
<i>Retrolental Fibroplasia: A Modern Parable</i> (Riley HD Jr) .....	336

1-30 Jan  
31-60 Feb  
61-96 Mar

97-132 Apr  
133-166 May  
167-208 Jun

209-298 Jul  
299-336 Aug  
337-362 Sep

363-406 Oct  
407-438 Nov  
439-467 Dec

(B) Book Review  
(C) Commentary

(E) Editorial  
(H) Health Dept

(L) Letter  
(S) Scientific

(Sp) Special



## Book Reviews (continued)

<i>Rickettsiae and Rickettsial Diseases</i> (Riley HD Jr) .	404
<i>Surface Anatomy. An Instruction Manual</i> (Riley HD Jr) .	335
<i>Surgical Infections: Selective Antibiotic Therapy</i> (Riley HD Jr) .	124
<i>Surgical Infectious Diseases.</i> (Riley HD Jr) .	230
<i>Survivors, Victims, and Perpetrators: Essays on the Nazi Holocaust</i> (Riley HD Jr) .	405
<i>Textbook of Pediatric Infectious Diseases</i> (Riley HD Jr) .	404
<i>Theories of Fever from Antiquity to the Enlightenment</i> (Riley HD Jr) .	438

## Commentary

The future of graduate medical education. Brandt EN Jr. .	340
Nightmare afternoon: The Star School disaster: Poarch JE .	313
Production and utilization of physicians in Oklahoma. Rich C .	217

## Deaths

Appleton, Meredith M, MD .	436
Bailey, Carl H. .	436
Bell, Austin H., MD .	121
Bennett, Henry G., Jr., MD .	60
Bowen, Adoniram V., MD .	60
Brown, Forest Reed, MD .	356
Buchan, William H., MD .	121
Capehart, Maurice P., MD .	403
Cash, Murray M., MD .	331
Cotteral, John R., MD .	466
Donaghe, Roy W., MD .	228
Freeman, Charles W., MD .	158
Hall, Clark H., MD .	60
Hill, Owen L., MD .	120
Karam, Hannah B., MD .	331
Kendall, Robert Lewis, MD .	356
Kerekes, Ernest S., MD .	356
Ledbetter, Marion K., MD .	356
Leebron, William M., MD .	158
Lindley, E. C., MD .	158
Lindley, Emmett Herbert, MD .	60
Lowery, Larry L., MD .	120
Lusk, Earl M., MD .	120
Martin, Louis A., MD .	206
McCain, Bernice Eugenie, MD .	436
McDonald, Glen Webster, MD .	158
McHenry, L. Chester, MD .	331
Moorman, James Floyd, MD .	403
Nelson, Franklin Jesse, MD .	331
Northrup, Robert Alan, MD .	436
Polk, Seigul J., MD .	331
Revere, Seth D., MD .	60
Rupp, Robert Ray, MD .	436
Spencer, Hugh Burns, MD .	436

Sullivan, Don D., MD .	206
Waters, Floyd L., MD .	158
White, Oscar R., MD .	403
Wilkins, Harry, MD .	120

## Editorials

Anatomy of a successful resolution. Eskridge JB III .	2
Anyone else need help? Johnson MR .	209
A divine suggestion. Johnson MR .	31
Great way to go. Johnson MR .	61
Heading into the sunset. Johnson MR .	167
The Hippocratic oath. Amen EM .	168
Let's give ourselves this year. Johnson MR .	363
Medical care triumphs. Johnson MR .	97
Monkey see, monkey do . . . Eskridge JB III .	32
No matter. Johnson MR .	1
Now now: The premorbid reflex. Johnson MR .	337
Phony drugs and foolish decisions. Johnson MR .	299
Some ironies about housecleaning. Johnson MR .	407
Something special . . . Eskridge JB III .	62
A student's view: A changing attitude in changing times. Silverstein S .	339
Not for Christmas only. Johnson MR .	439
Too bad to be true. Johnson MR .	133
Who listens?? Eskridge JB III .	98

## Index to Advertisers

Index to Advertisers . . . . .	28A (Jan), 32A (Feb), 38A (Mar), 42A (Apr), 34A (May), 34A (Jun), 34A (Jul), 30A (Aug), 30A (Sep), 32A (Oct), 34A (Nov), 26A (Dec)
--------------------------------	--

## In Memoriam

In Memoriam . . . . .	29, 60, 92, 121, 158, 206, 228, 331, 356, 403, 436, 466
-----------------------	---

## Instructions for Authors

Instructions for Authors . . . . .	28A (Jan), 32A (Feb), 38A (Mar), 42A (Apr), 34A (May), 34A (Jun), 34A (Jul), 30A (Aug), 30A (Sep), 32A (Oct), 34A (Nov), 26A (Dec)
------------------------------------	--

## The Last Word

The Last Word . . . . .	30A (Jan), 34A (Feb), 40A (Mar), 44A (Apr), 36A (May), 36A (Jun), 36A (Jul), 32A (Aug), 32A (Sep), 34A (Oct), 36A (Nov), 28A (Dec)
-------------------------	--

## Miscellaneous Advertisements

Miscellaneous Advertisements . . . . .	30, 11A (Feb), 96, 131, 166, 13A (Jun), 232, 11A (Aug), 362, 406, 13A (Nov), 466
--	--



## News

ACP announces its <i>Guide for Adult Immunization</i> . . .	88	DRG monitoring continues . . . . .	403
Agent orange (H) . . . . .	426	Dr Lambird elected to AMA Council on Medical Ser- vice . . . . .	227
Airborne measles virus infects children in physician's office . . . . .	155	Drug dependency problem? Call OSMA Physician Recovery Hotline . . . . .	222
AMA issues guidelines for patients with AIDS anti- bodies . . . . .	429	Elvin Amen, MD, takes the helm as OSMA president for 85-86 . . . . .	151
AMA issues guidelines to aid in diagnosis of child abuse . . . . .	351	ER admissions under DRG plan could produce "dumping" . . . . .	434
AMA offers new strategies as AIDS grabs more head- lines . . . . .	461	Evaluation of supplemental feeding program for women, infants, and children (WIC) (H) . . . . .	389
AMA plans shot in the arm for special projects this year . . . . .	151	Family physicians launch new drug information pro- gram . . . . .	59
AMA scientific council warns users of tanning beds, booths . . . . .	329	FDA likely to approve use of irradiation in food pro- cessing . . . . .	397
AMA seeks help of MDs, hospitals in PRO monitoring project . . . . .	225	Fiber in diet has benefits but cancer protection not included . . . . .	208
AMA slates April meeting on impaired health profes- sionals . . . . .	465	First five years of practice to be focus of AMA commit- tee . . . . .	118
AMA specialty journals join nationwide computer database . . . . .	205	Former dean of OU medical school assumes post at Houston hospital . . . . .	321
ACP warns MDs about their role in drug abuse prob- lems . . . . .	55	"Genes" not a lame excuse for alcoholics, study says . . . . .	463
ACSH and Ada lawsuit focus on smokeless tobacco . . . . .	90	Heart association now accepting applications for 1986-87 awards . . . . .	323
Alzheimer's marked by lower glucose metabolism in brain . . . . .	27	Hospitals consolidate labs, cut costs and save supplies . . . . .	197
AMA president-elect to attend OSMA's Annual Meet- ing in OKC . . . . .	87	Hypnosis has its shortcomings where testimony is concerned . . . . .	157
AMA to notify licensing boards about actions in other states . . . . .	117	Hypothermia in the elderly less common than sus- pected? . . . . .	434
August dates posted for PLICO's 1985 loss prevention seminars . . . . .	118	Infectious diseases in day care (H) . . . . .	455
August Life Members from Tulsa, Guymon, Broken Arrow . . . . .	429	Influenza surveillance system (H) . . . . .	219
Bane of travelers' existence becomes subject of NIH report . . . . .	355	In memoriam: William M. Leebron, MD, 1913-1985 . . . . .	153
Board certification growing in popularity among today's doctors . . . . .	118	In vitro fertilization labs a joint effort in Tulsa and OKC . . . . .	464
By the numbers: AMA reports trends in medical schools . . . . .	433	JCAH to include hospice programs in tailored sur- veys . . . . .	85
Cancer specialists want new DRG for research costs . . . . .	89	Lead screening project (H) . . . . .	148
Childhood obesity offers clue to atherosclerosis in adults . . . . .	399	Life memberships approved by Board of Trustees in November . . . . .	29
Cholesterol debate rumbles on as report stirs dis- agreement . . . . .	203	MAPS from AMA to aid in selection of practice sites . . . . .	391
Commercial hair analysis proves unreliable as diag- nostic tool . . . . .	392	Medicine takes giant steps in a year filled with firsts . . . . .	51
Computed tomography effective in reducing cost of diagnosis . . . . .	207	Meeting hosts election of OSMA officers and AMA delegates . . . . .	221
Congressman warns further cuts in Medicare may be skewed . . . . .	465	Mitsubishi plans test of AMA/NET among Japanese doctors . . . . .	402
DNR orders posing questions about ethics and deci- sions . . . . .	52	Most smokers kick the habit in solo, not group efforts.. . . .	56
Doctors and spouse take swings at Annual Meeting sports events . . . . .	225	Neonatal intensive care unit fosters hepatitis A out- break . . . . .	28
Doctors turn thumbs up on formal teaching of ethics . . . . .	56	New HCFA regulations threaten teaching nursing homes . . . . .	155
		NIH panel looks at dentists' use of general anesthe- sia . . . . .	397
		Norman MD wins VP spot with National Wildlife Federation . . . . .	327
		Occupational therapists must be licensed, says Okla- homa law . . . . .	350

1-30 Jan  
31-60 Feb  
61-96 Mar

97-132 Apr  
133-166 May  
167-208 Jun

209-298 Jul  
299-336 Aug  
337-362 Sep

363-406 Oct  
407-438 Nov  
439-467 Dec

(B) Book Review  
(C) Commentary

(E) Editorial  
(H) Health Dept

(L) Letter  
(S) Scientific

(Sp) Special

## News (continued)

Oklahoma County Medical sponsors television series .....	87	Oklahoma .....	349
Oklahoma delegation busy at AMA's June meeting in Chicago .....	326	Sufficient residency slots available, AMA study finds .....	51
Oklahoma's HERO, arriving in November, raises expectations .....	351	Take a break in the exhibit hall at Annual Meeting '85 .....	115
Oral contraceptives may increase risk of chlamydial infection .....	206	Teen alcohol use a predictor of later drug use and abuse .....	464
Organ transplants gain support but donor cards still scarce .....	329	Tendencies to depression and suicide seem to be inherited .....	401
OSMA Auxiliary Confluence held in OKC October 23-24 .....	431	Testing for HTLV-III antibody (H) .....	319
OSMA Board of Trustees approves new Life Memberships in February .....	115	Three days of business in OKC keep House of Delegates busy .....	222
OSMA Board of Trustees names Life Members at May meeting .....	349	Tulsa cardiovascular center sets June date for symposium .....	153
OSMA Board of Trustees names new deputy executive director .....	221	Tulsa medical students win \$33,000 in TCMS scholarships .....	430
OSMA seminar topics include management, financial planning .....	23	Tulsa meeting to focus on adolescent and pediatric care .....	323
Pediatric nutrition surveillance (H) .....	21	Videotape about loss prevention now available to state groups .....	121
"Perry A" sparkles in Chicago as clear choice for AMA post .....	325	Whooping cough (H) .....	195
Physicians Recovery Committee on the road in Oklahoma .....	85	Women increasing their lead in longevity sweepstakes .....	156
Physicians urged to consider hazards of patients' workplace .....	24		
Picnic in OKC draws large crowd .....	394		
Planned Parenthood book looks at methods, laws, and ethics .....	462		
Planning a meeting? Got a story? The JOURNAL would like to know .....	325		
PLICO Board of Directors adds new members at May meeting .....	225		
"PLICO Health alive and well," says Dr C. Alton Brown .....	199		
PLICO loss prevention seminars play to packed houses this fall .....	399		
PMTTC urges big turnout for "Alliances in Rural Health" .....	321		
Proceedings, Index to the .....	233		
Proceedings of the 79th Annual Meeting .....	233		
Program for 79th Annual Meeting .....	125		
Report on prescription drugs use says total still below '73 .....	90		
Report says high aspirin doses prevent Kawasaki complications .....	350		
Residents in Boston want more emphasis on "real world" skills .....	352		
Retrospective study suggests "defensive medicine" at work .....	327		
Salmonella strain in raw milk may be drug resistant, says CDC .....	197		
Smokeless tobacco (H) .....	48		
State doctors "get involved," get elected to key offices .....	457		
State workers' comp court adopts AMA guidelines .....	24		
Study examines factors in the success of female physicians .....	392		
Study using rifampin for Hib includes children in			

## News from the Oklahoma State Department of Health

News from the Oklahoma State Department of Health ..... 21, 48, 82, 112, 148, 195, 219, 319, 347, 389, 426, 455

## Pictures

Amen D .....	270
Amen EM .....	221, 236, 270, 284, 298, 14A (Jul), 326, 393, 394, 399, 458, 462
Amen K .....	270
Amen L .....	270, 14A (Jul)
Amen P .....	270
Amen R .....	270
Berger S .....	261
Bickham D .....	289, 326, 394, 462
Blair, D .....	289
Blaschke JA .....	222
Brandt EN Jr .....	240
Brown CA .....	199, 200
Burnett K .....	286
Burnett S .....	286
Bynum M .....	35A (May)
Calhoon EL .....	326
Camp P .....	395
Carr OA .....	279
Cornelison R .....	393
Coury J .....	221
Crosthwait MJ .....	326, 462, 465
Deen MA .....	35A (May), 254, 395, 431
Deen G .....	254
Dunitz NL .....	325, 394

Dumler B	286
Edge J	401
Ernest R	326, 393, 395
Eskridge JB III	234, 255, 281, 298, 326, 462
Eskridge M	284
Frates R	399
Harrison C	431
Harrison SR	286
Haugh MJ	325, 462
Hinshaw JR	229
Hinson D	286
Horowitz L	458
Johnson MR	222
Jones G	222
Kelsay E	296, 462
Lambird A	325
Lambird E	325
Lambird M	325
Lambird PA	227, 325, 327
Lambird S	325
Leverett T	286
Lewis CS	155, 297
Lively CE	458
Margo R	399
McCaffree DR	244
McCoy GA	222
McWatters A	286
Meeks S	286
Mellow MH	222
Miller FF	227, 285, 325, 326
Nelson AG	462
Norfleet EK	227
Oster P	281, 461
Paddock S	431
Peitersen S	394
Perryman RG	285
Pierce EC	399
Rhodes E	243
Rhodes RE Jr	282
Robards VL Jr	275, 327
Rogers HL Jr	238
Smith JD	431
Smith WR	457
Spears J	275
Stafford JW	290
Stonecipher C	261
Trotter LF	281, 401
Tytle C	35A (May)
Walters K	35A (May), 461
Weedn J	35A (May), 461
Welborn OM	282, 326, 462, 465
Whittington K	457

## President's Page

President's Page	2, 32, 62, 98, 134, 168 210, 300, 338, 364, 408, 440
------------------	---

## Reaction Time

Attorney invites editor to move to Russia. Berry HK III	123
Cooperation and congratulation echo from AMA meeting. Ramirez ME	358
Delegate reports AMA action on manpower problems. Coleman WO	332
Doctor calls for reevaluation of lipid in TPN. Hall WH	228
Editor's hammering on the mark. Hinson BR	161
Former dean sends letter of appreciation to OSMA friends. McCall CB	359
I'd do it again, Tulsan assures MRJ. Thompson JB	29
Lawsuit illustrates quandary. Rowsey JJ	124
"Now now reflex" observed in Claremore, says case report. Hrdlicka LJ	437
Reader disputes MRJ's "consensus." Westbrook BR	59
Retired OKC physician disputes MRJ's "gloom and doom" . . . Groom D	160
"Sad Consensus" editorial still provoking reactions from MDs. Bowman RC	358
Satellite call links McCurdys. McCurdy WC III	161
Senator replies to Amen letter. Boren DL	332
South Carolina doctor envies our status as unified state. Hawk JC Jr	358
Special Olympics director says thanks to OSMA. Kerr T	333
Tulsa doctor offers security tip. Horowitz L	332

## Scientific

Airborne bacterial contamination from patients on MA-1 volume ventilators. Thompson JE, Flournoy DJ	444
Bilaterally enlarged adrenal glands — an important clue to disseminated histoplasmosis. Chooi LMF, Fine DP, Muchmore HG, Carter MD, Wilson DA, Tisdal RG	301
Botulism — A case report. Riddle JD	441
A chronic illness and geriatric assessment, evaluation, and rehabilitation unit. Mohr JA, Long HL	380
Comparison of Rubazyme with haemagglutination inhibition test for determination of antibody to rubella virus. Qadri SMH, Chan GP	448
Continence-preserving operations in the management of ulcerative colitis. Postier RG, O'Malley V, Welsh JD	33
Continuous subcutaneous insulin infusion (CSII). Wilson DP, Endres RK	211
Diplopia: A review of 48 cases of isolated ocular cranial neuropathy. Wortham E V, Blumenthal H	99
Epidemiology of nontuberculous mycobacteria in Oklahoma. Omondi PPG, Asal NR, Muchmore Flournoy DJ	304
Home care: A better alternative for the ventilator-dependent child. de la Rocha SR	409

1-30 Jan  
31-60 Feb  
61-96 Mar

97-132 Apr  
133-166 May  
167-208 Jun

209-298 Jul  
299-336 Aug  
337-362 Sep

363-406 Oct  
407-438 Nov  
439-467 Dec

(B) Book Review  
(C) Commentary

(E) Editorial  
(H) Health Dept

(L) Letter  
(S) Scientific

(Sp) Special



## Scientific (continued)

Hypertension I: The relationship of hypertension to serum cholesterol, triglycerides, and sodium. Tsegaye A, Ritchey CR, Morrison RD .....	375
Hypertension II: Statistical correlation of seventy-eight diet components to blood pressure. Tsegaye A, Ritchey CR, Morrison RD .....	414
Intraoperative ultrasound. Streight R, Harolds JA ..	8
Limiting antibiotics on the hospital formulary. Westerman, EL .....	176
Nursing home glaucoma and visual acuity screening results in Garfield County. Newell SW, Walser JJ .....	16
Nutrition for the practitioner VI: Current concepts in nutrition: Vitamin K. Newmark SR .....	46
Observations on the hormonal response of metastatic prostatic carcinoma. Forrest JB .....	104
Oral anticoagulant-induced femoral nerve entrapment. Wood CL, Whang R .....	135
Orthopedic management of rheumatoid disease of the upper limb. Rayan GM .....	78
Outpatient cisplatin chemotherapy in a community hospital cancer center. Young JA, Segler S .....	343
Recent trends in pregnancy among teenagers in Oklahoma. Fermo AV, DePersio SR, Lorenz D, Oberle M .....	169
Results of a nutrition information study among family practitioners in Oklahoma County. Tinker RA .....	43
The role of the teaching nursing home in residency education. Walls LL, Prothro GW, Krenning LE, Pitts RJ, Price LD .....	72

Self-monitoring of blood glucose. Wilson DP, Rosenkoetter G, Endres RK .....	3
To shave or not to shave intravenous sites. Winter WK, Flournoy DJ .....	12
Turner syndrome: Clinical investigations and review. Wilson DP, Carpenter NJ, Holcombe JH .....	37

## Special Articles

An analysis of petitions for court commitment to psychiatric care filed in Tulsa County. Gajda JF ..	420
"Child crowing" (croup, 1836-1889). Greenwood RD ..	143
Coming attractions. Robinson MG .....	19
Early-day physician. Calhoon EL .....	453
Eliminating pharmacists' calls. Holt RJ .....	215
Epidemiologic study of prostate cancer in Oklahoma: Six-year review, 1975-1980. Odunze EE, Silberg SL, Mallonee J .....	139
Estimated physician manpower requirements for Oklahoma in 1990. Duffy FD, Lewis, CS Jr, Miller DA .....	183
HERO is here. Hardy RC .....	451
Keeping in touch: Notes from the OFPR. Thrift N ..	146
Leaders in medicine: William C. McCurdy, Jr., MD. Green R .....	65
Leaders in medicine: W. W. Rucks, Jr., MD. Green R ..	365
Physician manpower production critique, state of Oklahoma. OSMA Council on Medical Education ..	191
Physicians abroad: The wise women of Clamart. Chambers SL .....	106
Prison riot! Haines JD Jr .....	108
A study of 138 return service scholarship applications. Holmes JE, Miller DA .....	384

1-30 Jan  
31-60 Feb  
61-96 Mar

97-132 Apr  
133-166 May  
167-208 Jun

209-298 Jul  
299-336 Aug  
337-362 Sep

363-406 Oct  
407-438 Nov  
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(E) Editorial  
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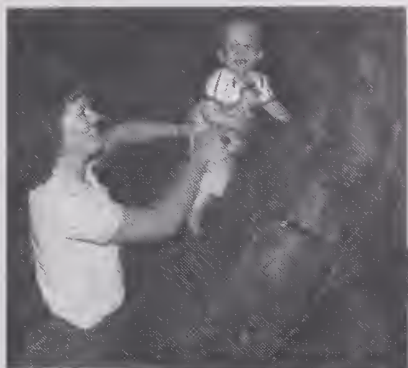
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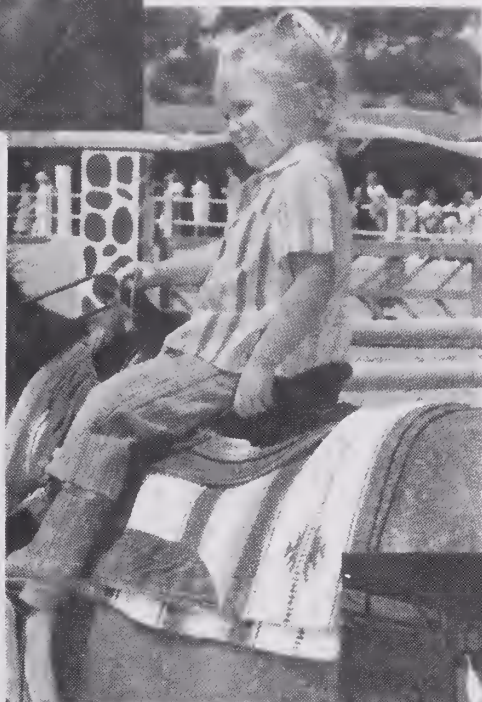
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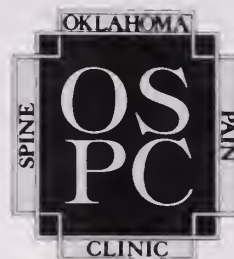
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## INDEX TO ADVERTISERS

The Arthritis Clinic .....	20A
The Cardiac Surgeons of Oklahoma City, Inc. ....	15A
Central Oklahoma Ambulatory Surgical Center, Inc. ....	22A
Comprehensive Medical Office Management, Inc. .	4A
Curtis 1000 Information Systems .....	9A
Edmond Medical Plaza .....	463
C. L. Frates & Co., Inc. ....	459
Glass-Nelson Clinic .....	18A
Harsha Orthopedic, Inc. ....	22A
Eli Lilly ( <i>Ceclor</i> ) .....	5A
Knoll Pharmaceuticals ( <i>Isoptin</i> ) .....	6A-8A
McAlester Clinic .....	18A
Medical Arts Clinic of Ardmore .....	19A
Medical Arts Laboratory .....	21A
James B. Morris II & Associates .....	4A
Oklahoma Allergy Clinic .....	16A
Oklahoma Center for Athletes .....	16A
Oklahoma City Clinic .....	IFC
Oklahoma Hand Surgery Center, Inc. ....	21A
Oklahoma Lung Function Laboratory .....	21A
Oklahoma Urology Center .....	22A
Orthopedic & Arthritis Center .....	19A
Orthopedic Associates .....	20A
OSMA Council on Member Services .....	11A
PLICO .....	12A
Professional Office Management .....	10A
Rehabilitation Institute of Oklahoma .....	460
Roche Products, Inc. ( <i>Limbitrol</i> , <i>Dalmane</i> ) .....	2A-4A, IBC, BC
RTS .....	456
Shawnee Medical Center Clinic, Inc. ....	17A
Southern Plains Medical Center, Inc. ....	17A
Tulsa Adjustment Bureau, Inc. ....	454
Willow View Hospital .....	14A
Windy Meadow Farm .....	13A

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### Style

All manuscripts should adhere to the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual for Authors & Editors*. Footnotes, bibliographies, and legends for illustrations should be typewritten, double-spaced, on separate sheets. References are to be listed in the order of their appearance in the article.

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### News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc., are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

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# Seasons Greetings!

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## THE LAST WORD

■ **Tulsa physician George Prothro, MD,** has been awarded top honor of the American Lung Association of Oklahoma, the Carl Puckett Memorial Award. The presentation was made during the group's annual meeting this summer. Prothro has been a member of the American Lung Association of Oklahoma since 1970, serving as chairman of more than a dozen of its committees, including the Executive Committee, and is a past president. Currently he is chairman of the Occupational Lung Disease Committee and the Long Range Planning Committee.

■ **"Does Nature Know Best? Natural Carcinogens in American Food"** is the title of a new report from the American Council on Science and Health (ACSH). It states that there are many naturally occurring carcinogens in the American food supply and encourages a more even balance in the evaluation of natural and manmade carcinogenic substances. "There's no reason to believe that natural carcinogens in food are a significant hazard to our health . . .," says the report. "In practice, natural carcinogens *can't* be avoided, since foods that contain them are so widespread. . . ." A complimentary copy of the booklet can be obtained by sending a self-addressed, stamped (39¢), business-size (#10) envelope to Natural Carcinogens Report, ACSH, 47 Maple Street, Summit, NJ 07901.

■ **The JOURNAL fell victim last month to the wiles of George Velliotis,** "the USA's infamous hoax-ter-jokester," as did the crowd at the Oklahoma Hospital Association's convention banquet. "Mr Put Ons," as Velliotis bills himself, appeared at the OHA's 66th Annual Meeting in Tulsa, addressing the banquet crowd under the alias of Sir Thomas Bagley-White, British Health minister. News of his visit was picked up from an OHA press release and duly reported in The Last Word in November. The hoax was a zealously guarded secret beforehand and the JOURNAL, like many of the guests in the audience that night, was completely fooled. Congratulations, OHA. Hawkeye and Trapper would have been proud of you!

■ **Further evaluation of the use of heparin** following transient ischemic attacks (TIAs) to prevent cerebral infarction is called for, according to a report in the *Archives of Neurology*. Heparin, which prevents clotting of blood, has been used since the 1940s, but

in a study of 74 patients Steven F. Putman, MD, and Harold P. Adams, Jr., MD, of the University of Iowa Hospitals in Iowa City, found that 12 patients had recurrent TIAs and 5 had cerebral infarction during treatment. In addition, 9 patients had bleeding complications. "Further evaluation of heparin therapy is appropriate," they say, pointing out that the only other therapeutic option now available would be use of antiplatelet-aggregating agents, whose value also is not known.

■ **The safety and effectiveness of a new vaccine** designed to prevent chickenpox has been demonstrated in a clinical trial among 137 healthy children, say Robert E. Weibel, MD, of the University of Pennsylvania in Philadelphia, and colleagues in the *Journal of the American Medical Association (JAMA)*. "The frequency of varicellalike rash was 3% (4 of 137); all rashes were mild," the researchers say. Most of the children, ages 1 to 12 years, showed evidence of immunity after two weeks; all showed evidence at four to six weeks. The Oka/Merck varicella vaccine was first evaluated in the US in 1981. To date, some 1,200 children have been immunized.

■ **Saccharin should continue to be available** as a food additive, and reports of adverse health effects associated with its use should be monitored, according to a report from the AMA's Council on Scientific Affairs. The report is based on a review of experimental and epidemiologic data related to the carcinogenicity of the sugar substitute. In humans, evidence indicates use of saccharin is not associated with an increased risk of bladder cancer, although experimental evidence in two-generation studies involving rats showed an incidence of bladder tumors, a "phenomenon for which there is currently no explanation."

■ **Orthopedic injuries sustained in motorcycle** accidents cost an average of \$17,704, according to a study by Timothy Bray, MD, and colleagues from the University of California, Davis. They reviewed 51 serial admissions, and found that more than half of the patients were intoxicated on admission, that 75% carried no insurance, and that 72% of the cost was paid by the state. "Care of motorcycle trauma consumes a substantial portion of public health care funds in California," they observe.



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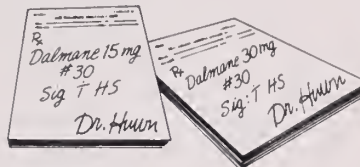
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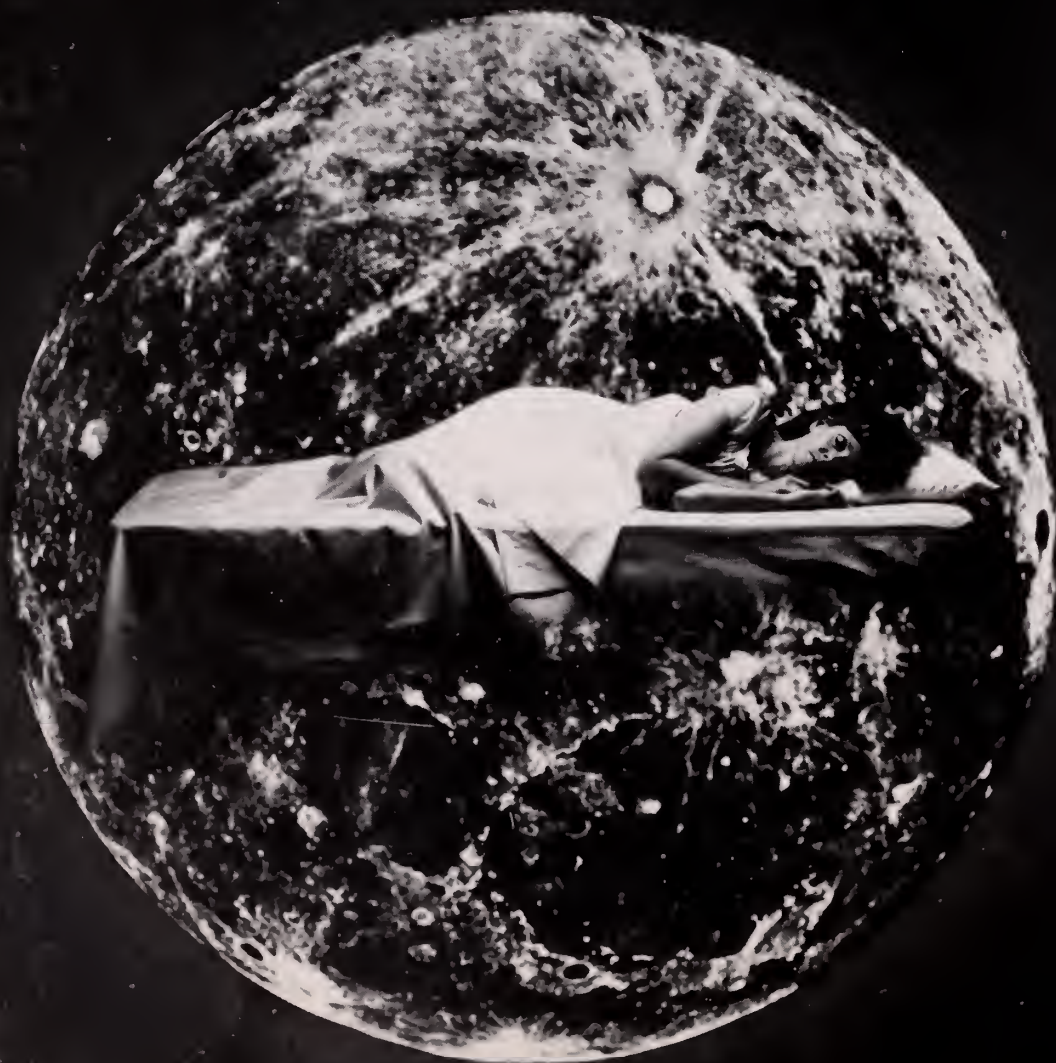


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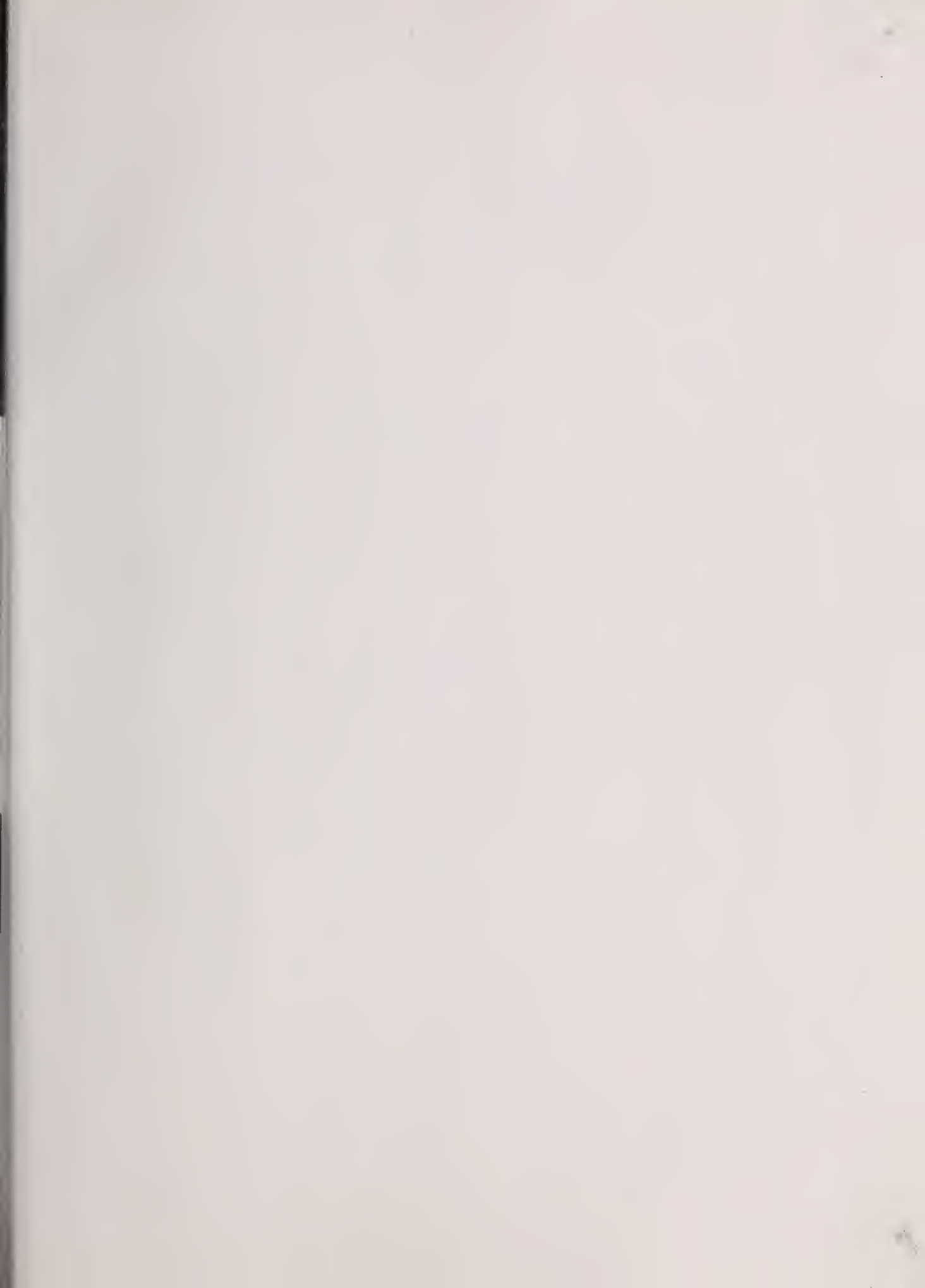
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**DUE IN 4 WEEKS UNLESS RENEWED**  
**NOT RENEWABLE AFTER 8 WEEKS**

[illegible]







